

Appendix B

Compliance and Confidentiality

Documentation Standards for Client Records

The documentation standards are described below under key topics related to client care. All standards shall be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas shall be included as appropriate as part of a comprehensive client record.
 - Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.
 - Presenting problems and relevant conditions affecting the client's physical health and mental health status shall be documented, for example: living situation, daily activities, and social support.
 - Documentation shall describe client strengths in achieving client plan goals.
 - Special status situations that present a risk to client or others shall be prominently documented and updated as appropriate.
 - Documentation shall include medications that have been prescribed by mental health plan physicians, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
 - Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
 - A mental health history shall be documented, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
 - For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
 - Documentation shall include past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs.
 - A relevant mental status examination shall be documented.
 - A five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, shall be documented, consistent with the presenting problems, history, mental status evaluation and/or other assessment data.
2. Timeliness/Frequency Standard for Assessment
 - The MHP shall establish standards for timeliness and frequency for the above-mentioned elements.

B. Client Plans

1. Client Plans shall:
 - have specific observable and/or specific quantifiable goals

- identify the proposed type(s) of intervention
- have a proposed duration of intervention(s)
- be signed (or electronic equivalent) by:
 - the person providing the service(s), or
 - a person representing a team or program providing services, or
 - a person representing the MHP providing services
- when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
 - a physician
 - a licensed/"waivered" psychologist
 - a licensed/registered/waivered social worker
 - a licensed/registered/waivered marriage and family therapist or
 - a registered nurse
- In addition,
 - client plans shall be consistent with the diagnoses, and the focus of intervention shall be consistent with the client plan goals, and there shall be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
 - client signature on the plan shall be used as the means by which the MHP documents the participation of the client
 - when the client is a long term client as defined by the MHP, and
 - the client is receiving more than one type of service from the MHP
 - when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability
 - the MHP shall give a copy of the client plan to the client on request

2. Timeliness/Frequency of Client Plan:

- Shall be updated at least annually.
- The MHP shall establish standards for timeliness and frequency for the individual elements of the client plan described in item 1

C. Progress Notes

1. Items that shall be contained in the client record related to the client's progress in treatment include:

- The client record shall provide timely documentation of relevant aspects of client care
- Mental health staff/practitioners shall use client records to document client encounters, including relevant clinical decisions and interventions

- All entries in the client record shall include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries shall include the date services were provided
- The record shall be legible
- The client record shall document referrals to community resources and other agencies, when appropriate
- The client record shall document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes shall be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)
- Day Treatment Intensive

c. Weekly

- Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered/registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service
- Day Rehabilitation
- Adult Residential

d. Other

- Psychiatrist health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services

Mental Health Services

WEEKLY WAIT TIMES REPORT

Contractor Name		Program Type	ADULT
Program Name		Provider Type	COUNTY
Contract Number		Report Period	
Sub Unit Number		Date Submitted	
Submitted By		Contact Phone	

[illegible]

Mental Health Services

WEEKLY WAIT TIMES REPORT

Contractor Name		Program Type	ADULT
Program Name		Provider Type	COUNTY
Contract Number		Report Period	
Sub Unit Number		Date Submitted	
Submitted By		Contact Phone	

[illegible]

Service Authorization Form
Interpreter Services for Clients – Access and Authorization

Instructions:

1. To request interpreter services, please complete Client Information, Service Information Section A, and Requester Information and fax to selected interpreter service provider.
2. Complete Service Information Section B after services have been provided or canceled and fax to interpreter service provider. For ongoing requests, an authorized County of San Diego representative should verify and submit the form for processing on a weekly basis.
3. Retain original form at program site for record of services provided.

Please “X” the Provider Selected:

- | <u>Service Provider:</u> | <u>Phone:</u> | <u>Fax:</u> | <u>Type of Interpreting:</u> |
|---|----------------------|--------------------|--------------------------------------|
| <input type="checkbox"/> Interpreters Unlimited | (800) 726-9891 | (800) 726-9822 | Oral/ Spoken Language Interpretation |
| <input type="checkbox"/> Deaf Community Services of San Diego, Inc. | (619) 398-2488 | (619) 398-2490 | American Sign Language |
| <input type="checkbox"/> Network Interpreting Services | (800) 284-1043 | (815) 425-9244 | American Sign Language |

Client Information:

The County of San Diego, HHSA has authorized the following interpreting services for:

Please Indicate Name of Client/Participant(s)

(If any participants are under age 18, please indicate age of minor(s): _____).

Language Requested: _____

Nature of Appointment: _____

Service Information:						
Section A:			Section B:			
Date:	Requested:		Actual:		Interpreter's Name: (If Services were canceled, please write "Canceled")	Verified By: (Initial and Date)
	Start Time	End Time	Start Time	End Time		

Requester Information:

Requester:

• Name: _____

• Phone: _____

• Fax: _____

• E-mail: _____

Agency Name: _____

Program Name and Address: _____

County Department to be Invoiced: _____

Manager/ Designee Approved By:

(Print Name) (Date)

(Signature) (Date)

Service Site: _____

(If different from Program Address)

Site Contact:

• Name: _____

• Phone: _____

• E-mail: _____

County of San Diego
Health and Human Services Agency (HHSa)

SERVICE AUTHORIZATION FORM INSTRUCTIONS

The purpose of Service Authorization Form is to request authorized scheduled interpreting services with contracted service providers and to verify that authorized scheduled interpreting services were provided **OR** cancelled and when they were cancelled.

The Service Authorization Form must be completed for each individual requiring interpreter services and authorizes services for one or more date(s) at the specified times and at a single location.

The form accompanying these Instructions dated 01/06/10 replaces all Service Authorization Forms previously in use to request interpreter services for clients/family members.

The Service Authorization Form may not be emailed with client information on it. A copy of the form may be provided to the interpreter if requested.

Note that oral interpreter services must be cancelled 24 hours in advance and American Sign Language (ASL) interpreter services must be cancelled 48 hours in advance. Please notify the client/family member of this requirement and ask them to contact your program in a timely manner if they need to cancel an appointment utilizing interpreter services. Services not cancelled timely will be charged to the County.

Instructions for Completing Section A:

- Select the Service Provider to be contacted by placing an “X” next to the Service Provider’s name.
- Circle either “client” or a “family member” to indicate who is receiving the interpreter services.
- Provide the name of the person/participant(s) needing interpreter services and the date(s) the services are required. If the person is under 18 years of age provide the age only, not the date of birth.
- Complete this section by providing the nature of appointment, language requested, requested start time, and end time. Next fill out all of the requestor information including agency name, program name and address, service site of where interpreting shall take place if different than the program address, and obtain approval by a manager or designee. Multiple appointments can be requested as long as they are at the same service site.
- Provide the name of the County department to be invoiced.
- **Mental Health programs** are required to indicate if the request is from a Children’s program or an Adult program.
- **FAX the Service Authorization Form with Section A completed to the service provider selected to officially request interpreter services.** * The selected service provider will call or email you to verify availability of interpreter staff.

Instructions for Completing Section B:

- If services were provided, state the date, actual start time, actual end time and the name of the interpreter. If services were cancelled, state the date and time the service request was cancelled.
- Provide initials of staff and date that were witness to services to verify information in Section B is accurate.
- **FAX the Service Authorization Form with Section B completed to the selected provider after the services have either been completed or cancelled.** *

It is an expectation that all programs will make every effort to develop bilingual/bicultural staff to reflect the population they serve. In this way, services will be delivered in a culturally competent manner, in the client’s preferred language; and interpreter services will be utilized more efficiently by everyone.

**Please note that some service providers may provide web based requesting services now or in the future. If the SAF is incorporated into their on-line services then the faxing of the form will not be necessary. Please verify this process with your service provider should there be any questions.*

Appendix D Providing Specialty Mental Health Services

SAN DIEGO COUNTY MENTAL HEALTH PLAN
72 – HOUR POST DISCHARGE LOG FOR SPECIALTY MENTAL HEALTH SERVICES

CARE COORDINATOR: _____

MONTH/YEAR: _____

Client Name	InSyst #	Admission Facility & Date of Admission	Date Program Learned of Admission	Date of Discharge	Date of Follow-up Appt.	Client Showed (yes or no)

**Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health
(Title IX 1830.205)**

- (a) The following medical necessity criteria determines Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.
- (b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:
 - (1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
 - (A) Pervasive Developmental Disorders, except Autistic Disorders
 - (B) Disruptive Behavior and Attention Deficit Disorders
 - (C) Feeding and Eating Disorders of Infancy and Early Childhood
 - (D) Elimination Disorders
 - (E) Other Disorders of Infancy, Childhood, or Adolescence
 - (F) Schizophrenia and Other Psychotic Disorders
 - (G) Mood Disorders
 - (H) Anxiety Disorders
 - (I) Somatoform Disorders
 - (J) Factitious Disorders
 - (K) Dissociative Disorders
 - (L) Paraphilias
 - (M) Gender Identity Disorder
 - (N) Eating Disorder
 - (O) Impulse Control Disorders not Elsewhere Classified
 - (P) Adjustment Disorders

- (Q) Personality Disorders, excluding Antisocial Personality Disorder
- (R) Medication-induced Movement Disorders related to other included diagnoses
- (2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:
 - (A) A significant impairment in an important area of life functioning.
 - (B) A probability of significant deterioration in an important area of life functioning.
 - (C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.
- (3) Must meet each of the intervention criteria listed below:
 - (A) The focus of the proposed intervention is to address the condition identified in (2) above.
 - (B) The expectation is that the proposed intervention will:
 - 1. Significantly diminish the impairment, or
 - 2. Prevent significant deterioration in an important area of life function, or
 - 3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
 - (C) The condition would not be responsive to physical health care based treatment.
- (c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

California State Penal Institutions

Avenal State Prison	Deuel Vocational Institution
California Correctional Center	Folsom State Prison
California Correctional Institution	High Desert State Prison
California Institution for Men	Ironwood State Prison
California Institution for Women	Mule Creek State Prison
California Medical Facility	North Kern State Prison
California Men's Colony	Northern California Women's Facility
California Rehabilitation Center	Pelican Bay State Prison
California State Prison, Corcoran	Pleasant Valley State Prison
California State Prison, Los Angeles County	Richard J. Donovan Correctional Facility at Rock Mountain
California State Prison, Sacramento	Salinas Valley State Prison
California State Prison, Solano	San Quentin State Prison
Calipatria State Prison	Sierra Conservation Center
Centinela State Prison	Valley State Prison for Women
California Substance Abuse Treatment Facility	Wasco State Prison
Central California Women's Facility	
Chuckawalla Valley State Prison	
Correctional Training Facility	

Mental Health Services Administration

Request for Verification of Veterans Eligibility To Counseling and Guidance Services

Confidential Fax Form

Directions: **Section 1: To be completed by client.**
 Section 2: To be completed by clinician and faxed to San Diego County Veterans Service Office
 Section 3: To be completed by San Diego County Veterans Service Office and faxed to clinician

Section 1: Client Claiming Veterans Eligibility Complete This Section Only

I hereby authorize the release of the information below to the County Veterans Service Office and the Veterans Administration for the purposes of identifying or obtaining benefits as a veteran or eligible dependent of a veteran. I also authorize the County Veterans Service Office and the Veterans Administration to release their findings (to be noted on this fax/form).

Signature: _____ Date: _____

Section 2: Mental Health Provider Complete This Side

To: Veterans Service Office
 Fax: (619) 232-3960

From: _____
 County or Contract staff (please print)

 Program name

 Address

 city/state/zip
 Phone: _____
 Comments _____

The client listed below claims to have veteran's status. Please verify eligibility to counseling and guidance services.

Name of Veteran: _____
 DOB: _____
 SSN: _____
 Date of Entry: _____
 Date of Discharge: _____
 Branch of Service: _____
 Military Serial Number: _____
 VA Claim Number: _____

Section 3: San Diego County Veterans Service Office Complete This Side

To: _____
 Fax: _____

From: _____
 CVSO Representative (please print)

 Address

 City/State/Zip
 Phone: _____
 Client Current Status _____

(Check appropriate boxes below)

☐ Client does not have eligibility to veteran's counseling and guidance services. Please assess for _____ mental health services.

☐ Client has been determined to be eligible to veteran's counseling and guidance services. Please refer client to the Veterans Service Center below:

☐ 2 790 Truxton Rd
 Ste. 130, San Diego CA 92106-6135
 (858) 642-1500

☐ 1 Civic Center Drive
 Suite 140
 San Marcos, CA 92069-2934
 (760) 744-6914

County of San Diego
 Health and Human Services Agency
 Mental Health Services
 Request for Verification of
 Veterans Eligibility to counseling and Guidance Services
 Confidential Fax Form
 HHSA: MHS-# 977(11/17/06)

Client: _____
MR/Client ID #: _____
Program: _____

START PROGRAM TCC & URC RECORD

Facility Name: _____

TCC/URC Date: _____

Client Name: _____

Admit Date: _____

Client attended this meeting? YES ☐ NO ☐ If no, explain: _____

Input from client (regarding treatment requests, suggestions or preference): _____

Progress and status of presenting symptoms (per client report & staff observations): _____

Response to Medications (per client report & staff observation): _____

Input from Other Mental Health Providers (if applicable): _____

Treatment Recommendations (effective interventions, treatment approach, focus of treatment, housing, follow-up treatment, medications...): _____

Change in Diagnostic Impression: ☐ No Change from Dx at Admission ☐ Change Noted Below

Axis I _____

Axis I _____

Axis II _____

Justification: _____

D/C Plans: **D/C Date:** _____ **Is client at risk for readmission?** No ☐ Yes ☐

Housing: _____ Finances: _____

Med Monitoring: _____ Tx: _____

Other: _____

Signatures of staff attendees: _____

DATE OF NEXT REVIEW:

REVIEW DATE: _____

Note Progress (sxs, med. changes, response to meds., extension needed...) _____

Signatures of staff attendees: _____

County of San Diego
Health and Human Services Agency
Mental Health Services

START TCC & URC RECORD (06/2005)

Client: _____

Medical Record No: _____

Program: _____

URC Minutes

Program Name: _____ Date: _____ Meeting Time: _____

Chairperson Name, Signature and Credentials: _____

Signatures of Committee Members (include credentials): _____

Client Name	Admit Date	Dates Authorized Through	Tentative D/C Date	Comments

NOTE: Requests for extensions and result will be noted in the "Comments" column
START Policy 606 Attachment A

This section to be used by Provider (Physician, Nurse, Therapist, Case Manager)

Provider

Name: _____

Date: _____

Although _____ (client name) has a MORs Rating of ____6, ____7 or ____8 on-going at the County or Contracted Outpatient Program are justified based on:

- ☐ Client has been in Long Term Care, had a psychiatric hospitalization, or was in a crisis residential facility in the last year
- ☐ Client has been a danger to self or others in the last six months
- ☐ Clients impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless
- ☐ Clients' behavior interferes with client's ability to get care elsewhere
- ☐ Complex psychiatric medication regimen is very complex

Comments and Treatment Plan:

This section to be used by Program Manager or designee

- ☐ Treatment justification for on-going services is supported.
- ☐ Treatment justification for on-going services not supported. See reverse for utilization management recommendation

Comments:

Signature: _____ Date: _____

Printed Name: _____

County of San Diego
Health and Human Services Agency
Mental Health Services

Utilization Management
Justification for On-going Services

Client: _____

MR/Client ID #: _____

Program: _____

Based on Utilization Management Review the following services are recommended:

_____ Recommended for referral to Primary Care:

- ☐ Stable functioning
- ☐ Low risk of harm
- ☐ High community support or independent
- ☐ High illness management skills
- ☐ Medications within scope of primary care
- ☐ No hospitalizations or Start admissions within last year

Comments and Transition Plan:

_____ Recommended for referral to FFS or FQHC Psychiatry services:

- ☐ Moderate functioning
- ☐ Low risk of harm
- ☐ Moderate community support or independent
- ☐ Moderate illness management skills
- ☐ Complex medications not within scope of primary care
- ☐ No hospitalizations or Start admissions within last six months

Comments and Transition Plan:

County of San Diego
Health and Human Services Agency
Mental Health Services

Utilization Management
Justification for On-going Services

Client: _____

MR/Client ID #: _____

Program: _____

Outpatient Utilization Review Minutes

Program Name:_____ Date:_____

Committee Members, Credentials:

Signatures:

Chairperson, Credentials:

Signature:

Client Name	InSyst#	Disposition		
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied

Outpatient Utilization Review Minutes
(continued)
Page ____ of ____

Program Name: _____ **Date:** _____

Client Name	InSyst#	Disposition		
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied
		<input type="checkbox"/> Request Approved	<input type="checkbox"/> Request Reduced	<input type="checkbox"/> Request Denied

Current Level of Case Management Services:

☐ Preventive (Maintenance)
☐ Comprehensive (Traditional)
☐ Intensive
☐ Older Adult

Location of Service	
Duration of Service	
Service Code	

☐ Assessment Reviewed ☐ No changes ☐ Changes noted/initialed

☐ Medical History Reviewed ☐ No changes ☐ Changes noted/initialed

☐ CFE Completed or Reviewed ☐ No changes ☐ Changes noted/initialed

☐ Client meets Medical Necessity for Mental Health Plan Specialty Mental Health Services by:

Current Diagnosis: Axis I _____ # _____. ____

Axis II _____ # _____. ____

AND:

☐ Client has a significant impairment in life functioning. **OR:**

☐ Client has a probability of significant deterioration in an important area of functioning

Describe:**AND all three of the following are true:**

☐ The focus of the mental health intervention will address the condition described above

☐ It is expected that the client will benefit from interventions listed on the revised or new Client Plan, which has been signed (☐ client refused to sign)

☐ The client's impairment would not be responsive to physical healthcare based treatment

AND:

☐ The client meets Service Level of Care Criteria for Case Management Services (Over)

Clinician Name

Signature

Date

The case manager's signature verifies that client meets both Medical Necessity and Service Level of Care Criteria

County of San Diego
 Health and Human Services Agency
 Mental Health Services
 Case Management Services

SIX MONTH REVIEW AND PROGRESS NOTE

HHSA:MHS-

Client:

Medical Record #:

Annual Review Date:

Page 1 of 2

SERVICE LEVEL OF CARE CRITERIA (Must Meet Either A or B)

A. FOR CONTINUING COMPREHENSIVE (TRADITIONAL) CASE MANAGEMENT SERVICES

Treatment history meets ONE of the following criteria

- _____ 10 days or 2 admissions for psychiatric inpatient treatment in the past twelve months
- _____ 28 days or 4 admissions to a crisis house in the past twelve months.
- _____ Discharge from an IMD in the past twelve months
- _____ LPS Conservatorship is in effect - Client is gravely disabled as a result of a mental disorder.

OR: TWO of the following are true regarding client's functioning

- _____ Client is a young adult (18 – 21) transitioning from the Children's System of Care.
- _____ Client is 55 or older and mental illness is exacerbated due to issues of aging or loss of support.
- _____ Client has at least (3) missed mental health appointments, or documentation that medication has not been taken on at least five occasions during the past twelve months, or has had two or more face-to-face encounters with crisis intervention/emergency services personnel; within the past twelve months
- _____ Besides mental health needs, client requires assistance with two or more human service agencies or public systems such as Drug and Alcohol, Vocational Rehabilitation, Criminal Justice, Physical Health Care, and Public Benefits. List the agencies:

- _____ Due to high risk behaviors, client has had one period of homelessness or one or more disruptions to placement or place of treatment in the past two years. List the disruptions

B. FOR CONTINUING CASE MANAGEMENT AT A PREVENTIVE (MAINTENANCE) LEVEL

BOTH of the following are true

1. _____ Client requires ongoing support and assistance from case management to attend psychiatric treatment appointments or obtain and take medications.
2. _____ Despite ongoing attempts by case manager to allow client to manage own funds and complete necessary paperwork to keep benefits in place, over the past twelve months, client has not been able to do so without assistance and there are no other persons available to provide the assistance.

Additional comments:

County of San Diego
Health and Human Services Agency
Mental Health Services
Case Management Services

SIX MONTH REVIEW PROGRESS NOTE

HHSA:MHS-

Client:

Medical Record #:

Annual Review Date:

Page 2 of 2

Case Management URC Record

Program Name: _____ URC Date: _____

Client Name: _____ Admission Date: _____

Client S#: _____

Primary Diagnostic Impression and Justification on Date of UR:

Axis I or Axis II:

Chart documents Medical Necessity:

_____ Yes _____ No

Comments:

Chart documents Service Necessity:

_____ Yes _____ No

Comments:

Recommended Level of Case Management Services:

Discharge Plan/Other Service Recommendations:

Name of person reviewing chart

Signature

URC Minutes for Case Management

Program Name:

Date of URC:

Committee Members

Print Name	Signature	Degree/License
Chair:		

List of Charts Reviewed

Client Name	Admit Date	Date Authorized Through	Continue at Same LOS	Transfer to Preventive LOS	Transfer to Comprehensive LOS	Discharge from Program	Comments
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	
			Y N	Y N	Y N	Y N	

Utilization Review Committee

Program: _____ Quarter/Date: _____

Participants: _____

Client Name: _____

Client ID # : _____

Provider/s name/s: _____

MORs History:

Date: _____	MORs: _____
Date: _____	MORs: _____
Date: _____	MORs: _____
Date: _____	MORs: _____
Date: _____	MORs: _____
Date: _____	MORs: _____

Root Cause Analysis:

Client Issues: _____

Environmental issues: _____

Clinical issues: _____

Other: _____

Disposition:

Client to continue services: _____

Client to be referred for services: _____

Client to be discharged: _____

Changes in Treatment Plan/Interventions: _____

Client Referred to: _____

Signature of Program Manager or Designee:

Appendix E Interface With Physical Health Care



HEALTHY SAN DIEGO COORDINATION OF CARE FORM GUIDELINES FOR PHYSICAL AND BEHAVIORAL HEALTH PRACTITIONERS

The purpose of the Healthy San Diego (HSD) Coordination of Care form is to provide a communication tool for use between physical and specialty mental health practitioners. Either side of the care continuum may initiate communication by completing the form, obtaining the client's written consent and forwarding the information to the appropriate practitioner. The use of the Coordination of Care form allows for exchange of essential medical information such as diagnosis and medications. By enhancing the communication between practitioners, HSD's goal of improved health outcomes can be achieved.

Primary Care Provider Responsibilities

The Primary Care Provider (PCP) is the primary case manager for the Health Plan member, and as such, makes referrals to specialists, as needed. The PCP is responsible for providing outpatient mental health services within his/her scope of practice. When the member requires Specialty Mental Health Services, the PCP will refer him/her to the Mental Health Plan for appropriate referral, assessment and treatment. The member may also self-refer to the Mental Health Plan's Access and Crisis Line.

- The PCP refers to Specialty Mental Health Services on the basis of objective and subjective evaluation of the member's medical history, psychosocial history, current state of health and any request for such services from either the member or the member's family.
- The PCP will inform the Specialty Mental Health Provider of any physical health conditions or medications which may influence possible mental health conditions.
- The PCP documents the mental health condition in the member's medical record.
- The PCP makes available to the Specialty Mental Health Provider any medical records and documentation relating to the member's mental health condition only if the client signs the Authorization to Release according to Health Plan policy and applicable laws and regulations.

Specialty Mental Health Provider Responsibilities

When a client requires physical health services, the Specialty Mental Health Provider will advise him/her to make an appointment with the PCP or contact the Health Plan's Member Services Department for assistance.

The Specialty Mental Health Provider may make available to the PCP the client's medical information relating to the diagnosis and plan of treatment only if the client signs the Authorization to Release, which allows specific medical information to be given to the PCP. The Specialty Mental Health Provider will inform the Primary Care Provider of any mental health conditions or medications which may influence possible physical health conditions. Mental health information will be shared according to the County Mental Health Plan policy and applicable laws and regulations.

Member/Client Responsibilities

Members/clients can access Specialty Mental Health Services through referrals from their PCP, family members or medical specialists. Clients also may access services directly by calling the County of San Diego Mental Health Plan Access and Crisis Line's toll free number (800) 479-9339 or by contacting a Specialty Mental Health Provider.

HSD's Coordination of Care form is available at www.ubhpublicsector.com

To Reach a Representative		
Blue Cross Of California Community Health Group	(800) 407-4627 (800) 404-3332	Health Net Kaiser Permanente Sharp Health Plan
	(800) 675-6110 (800) 464-4000 (800) 359-2002	Universal Care Access and Crisis Line
		(800) 635-6668 (800) 479-3339





COORDINATION OF CARE

BETWEEN PHYSICAL & BEHAVIORAL HEALTH PRACTITIONERS

SECTION A. CLIENT INFORMATION					
Name Last		First	Middle Initial	AKA	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address			Date of Birth		
City			Telephone #		
Zip			Alternate Telephone #		
SECTION B. BEHAVIORAL HEALTH PRACTITIONER INFORMATION					
Name					
Organization OR Medical Group					
Street Address			City, State, Zip		
Telephone #			Fax #		
Date of Initial Assessment		Diagnosis		Diagnosis	
Current Symptoms					
Current Medications					
Summary of Patient Evaluation			Current Treatment Plan		
SECTION C. PHYSICAL HEALTH PRACTITIONER INFORMATION					
Name					
Organization OR Medical Group					
Street Address			City, State, Zip		
Telephone #			Fax #		
Date of Initial Assessment		Diagnosis		Diagnosis	
Current Symptoms					
Current Medications					
Summary of Patient Evaluation			Current Treatment Plan		
To Reach a Plan Representative					
Blue Cross Of California Community Health Group		(800) 407-4627 (800) 404-3332		Health Net (800) 675-6110 Kaiser Permanente (800) 464-4000 Sharp Health Plan (800) 359-2002	
				Universal Care (800) 635-6668 United Behavioral Health (800) 479-3339	



Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

SECTION D SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:

DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

FOR OFFICE USE

ID VALIDATION

SIGNATURE OF STAFF PERSON VALIDATING IDENTIFICATION:

DATE:

SIGNATURE OF HEALTH CARE PROVIDER:

DATE:

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the following medical records and information concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

- o Information Contained on this form
- o Current Medication & Treatment Plan
- o Substance Dependence Assessments
- o Assessment /Evaluation Report

- o Discharge Reports/Summaries
- o Laboratory/Diagnostics Test Results
- o Medical History
- o Other _____

To Reach A Health Plan Representative Call:

Blue Cross Of California (800) 407-4627
Community Health Group (800) 404-3332
Health Net (800) 675-6110
Kaiser Permanente (800) 464-4000
Sharp Health Plan (800) 359-2002
Universal Care (800) 635-6668
United Behavioral Health (800) 479-3339

Client Name { Please type or print clearly}

(Last) _____

(First) _____

I would like a copy of this authorization.

☐ Yes ☐ No Initials



**PLACE A COPY OF THIS FORM
IN THE CLIENT'S MEDICAL RECORD**

COUNTY OF SAN DIEGO
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

DATE: _____

PATIENT/CLIENT/ FACILITY RESIDENT

LAST NAME: _____

FIRST NAME: _____

MIDDLE INITIAL: _____

ADDRESS: _____

CITY/STATE: _____

ZIP CODE: _____

TELEPHONE NUMBER: _____

SSN (OPTIONAL): _____

DATE OF BIRTH: _____

AKA'S: _____

THE FOLLOWING IS AUTHORIZED TO MAKE THE DISCLOSURE.

NAME OR ENTITY: _____

ADDRESS AND TELEPHONE NUMBER: _____

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING.

NAME OR ORGANIZATION: _____

ADDRESS AND TELEPHONE NUMBER: _____

TREATMENT DATES: _____

PURPOSE OF REQUEST:

☐ AT THE REQUEST OF THE INDIVIDUAL.

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- | | |
|--|---|
| <p><input type="checkbox"/> History and Physical Examination</p> <p><input type="checkbox"/> Discharge Summary</p> <p><input type="checkbox"/> Progress Notes</p> <p><input type="checkbox"/> Medication Records</p> <p><input type="checkbox"/> Interpretation of images: x-rays, sonograms, etc.</p> <p><input type="checkbox"/> Laboratory results</p> <p><input type="checkbox"/> Dental records</p> <p><input type="checkbox"/> Psychiatric records including Consultations</p> | <p><input type="checkbox"/> HIV/AIDS blood test results; any/all references to those results</p> <p><input type="checkbox"/> Physician Orders</p> <p><input type="checkbox"/> Pharmacy records</p> <p><input type="checkbox"/> Immunization Records</p> <p><input type="checkbox"/> Nursing Notes</p> <p><input type="checkbox"/> Billing records</p> <p><input type="checkbox"/> Drug/Alcohol Rehabilitation Records</p> <p><input type="checkbox"/> Complete Record</p> <p><input type="checkbox"/> Other (Provide description) _____</p> |
|--|---|

County of San Diego
AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

Client: _____
Record Number: _____
Program: _____

Patient/Client/Facility Resident or their
Legal Representative's Initials: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

I have the right to receive a copy of this authorization. I would like a copy of this authorization.
☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:

DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

FOR OFFICE USE

Please verify that the patient/client/facility resident or their legal representative has initialed each page of this authorization.

VALIDATE IDENTIFICATION ☐

SIGNATURE OF STAFF PERSON:

DATE:

**County of San Diego
AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION**

Client: _____
Record Number: _____
Program: _____

Appendix F Beneficiary Rights Issue Resolution

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

I. BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

PLEASE NOTE: PROVIDERS SHALL NOT SUBJECT A CLIENT TO ANY DISCRIMINATION OR ANY OTHER PENALTY OF ANY KIND FOR FILING A GRIEVANCE, APPEAL OR EXPEDITED APPEAL.

A. PROCESS

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

- 1) Grievance process
- 2) Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level of service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Mental Health Plan (MHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

- 3) Expedited Appeal process (available in certain limited circumstances)
- 4) State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Mental Health Program (MHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the MHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County MHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5, Section 1850.205 and 42 CFR Subpart F, Part 438.400. **The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document.** By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. OBJECTIVES

1. To provide the consumer with a process for independent resolution of grievances and appeals.
2. To protect the rights of consumers receiving mental health services, including the right to:
 - Be treated with dignity and respect,
 - Be treated with due consideration for his or her privacy,
 - Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
 - Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
 - Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
 - Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
 - Freely exercise these rights without adverse effects in the way providers treat him or her.
3. To protect the rights of consumers during grievance and appeal processes.
4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.
5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.
6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites.

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

C. BENEFICIARY and CLIENT RIGHTS DURING THE GRIEVANCE AND APPEAL PROCESS

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.
2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.
3. Consumers shall be informed of their right to contact the Jewish Family Service (JFS) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.
4. Consumers of the MHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the JFS Patient Advocacy Program and CCHEA, the programs that currently are contracted with the MHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages, and shall be given to the client at the point of intake to Mental Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.
5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.
6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.
7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.
8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.
9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.
 - Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.
 - Medi-Cal beneficiaries, who have appealed through the MHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 90 days of the decision whether or not the client received a Notice of Action

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

(NOA). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See Section VIII for more information on the State Fair Hearings.)

- Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the MHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.
- Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the MHP and the Quality Review Council for implementation of system changes, as appropriate.

D. CLIENT AND BENEFICIARY NOTIFICATION

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact JFS Patient Advocacy and CCHEA. The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.
2. Notices in threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.
3. Grievance/Appeal forms and self-addressed envelopes must be available for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.
4. CCHEA and Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.
5. Under certain circumstances, when the MHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the MHP must provide the Medi-Cal beneficiary with a Notice of Action (NOA), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from JFS or CCHEA.

II. INFORMAL PROBLEM RESOLUTION –available to all mental health clients

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution. **However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.**

In addition to, or instead of, bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. GRIEVANCE PROCESS—available to all mental health clients

Any consumer of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through JFS Patient Advocacy (for inpatient and residential services) or the Consumer Center for Health Education and Advocacy (for outpatient and all other mental health services).

IV. GRIEVANCE PROCEDURES:

At any time the consumer chooses, the consumer may contact CCHEA or JFS Patient Advocacy, as appropriate. CCHEA or JFS Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts JFS Patient Advocacy Program for issues relating to inpatient and other 24-hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see Section IV for complete definition.).

NOTE: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see Section X for Definition) not a grievance. See "Appeal Process" in Section V below for procedure.

2. CCHEA or Patient Advocacy Program logs the grievance within one working day of receipt. The log shall include:
 - the client name or other identifier,
 - date the grievance was received,
 - the date it was logged, the nature of the grievance,
 - the provider name,
 - whether the issue concerns a child.

The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.

3. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance within three working days.
4. CCHEA or Patient Advocacy Program shall contact the provider involved in the grievance as soon as possible and within three working days of receipt of the client's written permission to represent the client.

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

5. CCHEA or Patient Advocacy Program investigates the grievance.
 - CCHEA or JFS shall ensure that the person who makes the final determination of the grievance resolution has had no prior or current involvement in the grievance determination.
 - In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.
 - The client's confidentiality shall be safeguarded per all applicable laws.
6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's condition.
7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or JFS and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If a case should arise in which CCHEA or JFS and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or JFS shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the MHP Director or designee. CCHEA or JFS may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of the matter. Notification of the resolution shall go out to all parties as described below.
8. CCHEA or Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:
 - the date
 - the resolutionA copy of the grievance resolution letter will be sent to the provider and the QI Unit at the time the letter is sent to the client.
9. Timelines for grievance dispositions cannot exceed 60 calendar days from the date of receipt of the grievance. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete. Timeliness of grievance resolution is an important issue for consumers. If an extension is required, CCHEA or JFS will contact the client to discuss an extension, clearly

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

document in the file the extenuating circumstances that indicate the need for the extension, and the date the client was contacted and agreed to an extension. If the timeframe extension was not requested by the client, CCHEA or JFS staff must give the client written notice of the reason for the delay. If CCHEA or JFS staff is unable to meet the timeframe described herein, the staff person shall issue a Notice of Action D (NOA-D) to the beneficiary informing them of their rights. A copy of the NOA-D shall be sent to the QI Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

10. CCHEA or JFS Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason there has not been a final disposition of the grievance.
11. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or JFS. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within 10 working days directly to:

Grievance Plan of Correction
Quality Improvement Unit
P.O. Box 85524, Mail Stop P531G
Camino Del Rio South
San Diego, CA 92186-5524

The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or JFS's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the MHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the MHP directly with the provider.

In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization, and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the MHP. This request shall be submitted directly by the provider to the MHP Director or designee within 10 working days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

GRIEVANCE PROCESS

STEP	ACTION	TIMELINE
1	Grievance Filed by client	Filing Date

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

2	Grievance Logged	1 Working Day from Grievance Filing
3	Written Acknowledgement to client	3 Working Days from Grievance Filing
4	Provider Contact	Within 3 Working Days from Client's Written Permission to Represent
5	Clinical Consultant review, if applicable	Within 60 day total timeframe
6	Grievance Disposition	60 Days from Filing Date
7	Disposition Extension (if needed)	14 Calendar Days from the 60 th day
8	Provider Plan of Correction (if needed)	10 Working Days from Disposition Date
9	Request for Administrative Review	10 Working Days from receipt of the Grievance Disposition

V. **APPEAL PROCESS—available to Medi-Cal Beneficiaries only**

The appeal procedure begins when a Medi-Cal beneficiary contacts JFS Patient Advocacy Program (for issues relating to inpatient and other 24 hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an “action.”

An “action” is defined by 42 Code of Federal Regulations as occurring when the MHP does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the MHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the MHP or its administrative services organization, may use the grievance process.

The MHP is required to provide *Aid Paid Pending* for beneficiaries who want continued services, and have made a timely request for an appeal:

- within 10 days of the date the NOA was mailed, or
- within 10 days of the date the NOA was personally given to the beneficiary, or
- before the effective date of the service change, whichever is later.

The MHP must ensure that benefits are continued while the appeal is pending, if the beneficiary so requests. The beneficiary must have:

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

- an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see Section X. Definitions).

The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

VI. APPEAL PROCEDURES

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.
2. CCHEA or JFS Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in section VI below.
3. CCHEA or Patient Advocacy Program logs the appeal within one working day of receipt. The log shall include the:
 - client name or other identifier,
 - date the appeal was received,
 - date the appeal was logged,
 - nature of the appeal,
 - the provider involved,
 - and whether the issue concerns a child.

The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, CCHEA or JFS will summarize in writing the content pertaining to the client.

4. CCHEA or JFS shall acknowledge, in writing, receipt of the appeal within three working days.
5. CCHEA or JFS shall contact the provider as soon as possible and within three working days of receipt of the client's written authorization to represent the client.
6. CCHEA or JFS Patient Advocacy Program shall notify the QI Unit within three working days of any appeal filed.
7. CCHEA or JFS evaluates the appeal and:

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

- Ensures that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.

- Safeguards the client's confidentiality per all applicable laws.

In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QI Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.
9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If CCHEA or JFS denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or JFS believes that there is sufficient merit to grant an appeal regarding an action that:
 - denied or limited authorization of a requested service, including the type or level of service,
 - reduced, suspended or terminated a previously authorized service, or
 - denied, in whole or in part, payment for a service, CCHEA or JFS shall do the following within 30 calendar days of the date the appeal was filed:
 - a) notify the MHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and
 - b) provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

In some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days for good cause, such as a satisfactory resolution is pending but not complete.

11. The MHP Director or designee shall return a decision on the appeal to the advocacy organization within 10 calendar days of receipt of the above.
12. CCHEA or JFS shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

include:

- the date,
 - the resolution,
 - and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
 - the right to request a State Fair Hearing within 90 days of notice of the decision,
 - how to request a State Fair Hearing, and
 - the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.
 - A copy of the appeal resolution letter will be sent to the provider and the Quality Improvement (QI) Unit at the time the letter is sent to the client.
13. Appeals must be resolved within 45 calendar days (59 calendar days if extension granted) from the date of receipt of the appeal. Timeliness of appeal resolution is an important issue for consumers. If an extension is required, CCHEA or Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.
 14. If the timeframe extension was not requested by the client, CCHEA or Patient Advocacy staff must give the client written notice of the reason for the delay. The notice shall include the client's right to file a grievance if the client disagrees with the decision to extend the timeframe.
 15. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOA-D to Medi-Cal beneficiaries only. A copy shall be sent to the QI Unit. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.
 16. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

APPEALS PROCESS

STEP	ACTION	TIMELINE
1	Appeal Filed by client	File Date
2	Appeal Logged	1 Working Day from Appeal
3	Expedited Appeal Criteria?	Go to Section VII
4	Written Acknowledgement of appeal to client	3 Working Days from Receipt of Appeal
5	Provider Contact	3 Working Days from Client's Written Permission to Represent
6	Clinical consultant review, if applicable	As soon as possible
7	Notify QI Unit	3 Working Days of Appeal Filing
8	Advocacy Organization recommends denying	See #10 for timelines

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	appeal	
9	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation	Within 30 calendar days from date appeal was filed
10	MHP Director makes decision on the appeal	Within 10 calendar days from receipt of appeal.
11	Appeal Resolution	45 Calendar Days from Receipt of Appeal
12	Appeal Extension (if needed)	14 Calendar Days from Extension Filing Date

VIII. EXPEDITED APPEAL PROCESS—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the MHP, or CCHEA or JFS Patient Advocacy program staff, jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. EXPEDITED APPEAL PROCEDURES

1. The client may file the expedited appeal orally or in writing.
2. The CCHEA or Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:
 - client name or other identifier,
 - date appeal was received,
 - date the appeal was logged,
 - nature of the appeal,
 - provider involved,
 - and whether the issue concerns a child.
4. The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.
5. CCHEA or Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two working days.
6. CCHEA or Patient Advocacy Program shall notify the QI Unit immediately of any expedited appeal filed. CCHEA or Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two working days.
7. The client or his or her representative may present evidence in person or in writing.
8. CCHEA or Patient Advocacy Program evaluates the expedited appeal.
 - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.

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- The client's confidentiality shall be safeguarded per all applicable laws.
9. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.
 10. If, CCHEA or Patient Advocacy Program, finds that the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or Patient Advocacy program staff shall:
 - Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.
 - Transfer the appeal to the timeframe for standard appeal resolution (above), and
 - Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process, and follow up within two calendar days with a written notice. A copy of the letter shall be sent to QI.
 11. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

If CCHEA or JFS denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14.*

12. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:
 - denied or limited authorization of a requested service, including the type or level of service,
 - reduced, suspended or terminated a previously authorized service, or
 - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two working days of the date the appeal was filed:
 - notify the MHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and
 - provide copies to the MHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the expedited appeal.
13. The MHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one working day of receipt of the above.

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14. CCHEA or Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:
 - the date,
 - the resolution,
 - and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary
 - information regarding the right to request an expedited State Fair Hearing
 - information on how to request continued services (aid paid pending) while the hearing is pending.

A copy of the appeal resolution letter will be sent to the provider and the QI Unit at the same time the letter is sent to the client.
15. Expedited appeals must be resolved and the client must be notified in writing within three working days from the date of receipt of the expedited appeal. However, in some limited instances, it may be necessary for the timeframe to be extended by up to 14 calendar days if the client requests an extension. In rare circumstances, the timeframe may be extended up to the 14 calendar days if CCHEA or JFS staff determines that there is a need for more information AND that the delay is in the client's best interest.
16. If the timeframe extension was not requested by the client, CCHEA or JFS Patient Advocacy staff must give the client written notice of the reason for the delay.
17. If CCHEA or JFS staff is unable to meet the timeframe described herein, they shall issue an NOA-D to the beneficiary. A copy shall be sent to the QI Unit.
18. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.
19. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

EXPEDITED APPEAL PROCESS

STEP	ACTION	TIMELINE
1	Expedited Appeal Filed by client	File Date
2	Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal.	If no, notify client in 2 calendar days in writing
3	Expedited Appeal Logged	1 Working Day from Appeal receipt
4	Written Acknowledgement of appeal to client	2 Working Days from Receipt of Appeal
5	Provider Contact	2 Working Days from Client's Written Permission to Represent

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6	Notify QI Unit	Immediately
7	Advocacy Organization recommends denying appeal	See #10 above for timelines
8	Advocacy Organization recommends granting the appeal, and notifies MHP Director in writing with supporting documentation.	Within 2 working days from date appeal was filed
9	MHP Director makes decision on the appeal	Within 1 working day from receipt of notification from the Advocacy Organization
10	Appeal Resolution	3 Working Days from Receipt of Appeal
11	Disposition Extension (if needed)	14 Calendar Days from 3 rd working day.

X. STATE FAIR HEARING—available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within 90 days after the completion of the MHP beneficiary problem resolution process, whether or not the client received a Notice of Action (NOA), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the MHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at 1(800) 952-5253, or by contacting CCHEA or JFS Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the MHP QI Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QI Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.
2. Attend the hearing to represent the MHP position.
3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.
4. The MHP is required to provide *Aid Paid Pending* for beneficiaries who want

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continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:

- within 10 days of the date the NOA was mailed, or
 - within 10 days of the date the NOA was personally given to the beneficiary, or
 - before the effective date of the service change, whichever is later.
- 5. The beneficiary must have:
 - an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP, or
 - been receiving specialty mental health services under an ‘exempt pattern of care’ (see Section XII. Definitions).
- 6. The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.
- 7. After a judge has heard a case, he or she forwards the decision to the MHP QI Unit. In the event that the case is not resolved in the MHP’s favor, the QI Unit staff shall communicate the decision and any actions to be implemented, to the MHP Program Monitors to oversee implementation of the resolution by the County-operated and/or contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Action (NOA) has been issued.

XI. MONITORING GRIEVANCES AND APPEALS

The MHP QI Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The MHP QI Unit shall review the files of CCHEA and JFS Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein, and ensure that consumer rights under this process are protected to the fullest extent.
2. On a monthly basis, by the 20th of the following month, JFS Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the MHP QI Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:
 - client name or other identifier
 - date the grievance or appeal was filed,

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- date logged
 - nature of the grievance or appeal
 - provider involved,
 - and whether the issue concerns a child.
3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.
 4. The MHP QI Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, MHP Director, and/or Mental Health Board for recommendations or action as needed. The MHP QI Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

1. CCCHEA and JFS Patient Advocacy shall report to the QI Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QI Unit also.
2. The QI Unit will investigate all such complaint clusters.
3. Findings will be reported to the MHP Director.

XII. DEFINITIONS

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

BENEFICIARY AND CLIENT PROBLEM RESOLUTION POLICY AND PROCESS

Action:	<p>As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:</p> <ul style="list-style-type: none">• Denies or limits authorization of a requested service, including the type or level of service;• Reduces, suspends, or terminates a previously authorized service;• Denies, in whole or in part, payment for a service;• Fails to provide services in a timely manner, as determined by the MHP or;• Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
Appeal:	<p>A request for review of an action (as action is defined above).</p>
Beneficiary:	<p>A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.</p>
Client:	<p>Any individual currently receiving mental health services from the County MHS system, regardless of funding source.</p>
Consumer Center for Health Education and Advocacy (CCHEA):	<p>CCHEA is an MHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community.</p>
Consumer:	<p>Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)</p>
Grievance:	<p>An expression of dissatisfaction about any matter other than an action (as action is defined).</p>

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Grievance and Appeal Process:	A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services.
Mental Health Plan (MHP):	County of San Diego, Health & Human Services Agency, Mental Health Services.
Notice of Action (NOA):	<p>A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.</p> <p>NOA-A: (Assessment) Denial of service sent from providers to Medi-Cal beneficiaries when the face-to-face assessment indicates they do not meet medical necessity criteria and no specialty mental health services will be provided.</p> <p>NOA-B: (Denial of Services) Denial or modification of provider's request for Medi-cal services requiring pre-authorization. The denial is sent from the point of authorization to both provider and beneficiary, when the beneficiary did not receive the service.</p> <p>NOA-C: (Post-Service Denials) Denial or modification of provider's request for specialty mental health services sent from the point of authorization to both the provider and the beneficiary, when the beneficiary has already received the service.</p> <p>NOA-D: (Delayed Grievance/Appeal Decisions) Notice sent by advocacy contractor to the beneficiary when the resolution of the grievance, appeal or expedited appeal was not provided within the required timeframe.</p> <p>NOA-E: (Lack of Timely Services) Notice sent by provider to beneficiary when the provider does not provide services in a timely manner according to the MHP standards for timely services.</p>

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Patients' Rights Advocate:	<p>The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services, and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."</p> <p>JFS Patient Advocacy Program staff currently serve as the Patients' Rights Advocate for acute inpatient and other 24-hour residential services, and CCHEA staff serve as the Patients' Rights Advocate for outpatient, day treatment, and all other services.</p>
Quality Improvement (QI) Program:	<p>The Quality Improvement Program is a unit within HHSA Mental Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.</p>
State Fair Hearing:	<p>A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.</p>
Jewish Family Service (JFS) Patient Advocacy Program:	<p>The Jewish Family Service Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient's rights.</p>

County of San Diego
Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number: _____

The mental health plan for San Diego County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

- ☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).
- ☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).
- ☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).
- ☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of the Access and Crisis Line at (800) 479-3339.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan through the Access and Crisis Line at (800) 479-3339 or write to: United Behavioral Health Access and Crisis Line, P.O. Box 601370, San Diego, CA 92160-1370.

You may file an appeal with your mental health plan. For inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. Or you can follow the directions in the information pamphlet the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, for inpatient/residential services, you may call and talk to or write a representative of JFS Patient Advocacy Program at (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. For outpatient and all other mental health services, you may call and talk to or write a representative of the Consumer Center for Health Education and Advocacy at (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

**County of San Diego
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION**

Date: _____

To: _____ Medi-Cal Number _____

The mental health plan for San Diego County has ☐ denied ☐ changed your provider's request for payment of the following service(s):

The request was made by: (provider name) _____

The original request from your provider was dated _____

The mental health plan took this action based on information from your provider for the reason checked below:

- ☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).
- ☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____

- ☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).
- ☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.
- ☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____

- ☐ Other: _____

If you don't agree with the plan's decision, you may:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370; or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____.
2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____. The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.
3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at (800) 479-3339 or write to: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the first box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for a Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. For problems with inpatient and residential mental health services, call JFS Patient Advocacy Program at 800-479-2233. For problems with outpatient and all other mental health services, call toll free the Consumer Center for Health Education and Advocacy at 877-734-3258. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253

If you are deaf and use TDD, call: 1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with

the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of San Diego County.

- ☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

- ☐ Check here and add a page if you need more space.

My Name: (print) _____

My Social Security Number: _____

My Address: (print) _____

My Phone Number: () _____

My Signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name: _____

Address: _____

Phone Number: () _____

Condado de San Diego
Programa de Especialidades de Salud Mental de Medi-Cal
AVISO DE ACCIÓN
(Evaluación)

Fecha: _____

Para: _____ Número de Medi-Cal _____

El plan de salud mental del Condado de San Diego ha decidido, después de revisar los resultados de la evaluación de su condición mental, que su condición mental no cumple con el criterio de necesidad médica para ser elegible para recibir servicios de salud mental especializados a través del plan.

En opinión del plan de salud, su condición de salud mental no cumple con el criterio de necesidad médica que se encuentra cubierto en los reglamentos estatales, Título 9, Sección 1830.205 del Código de Regulaciones de California (CCR), por la razón que se marca a continuación:

- ☐ Su diagnóstico de salud mental, según se identifica por medio de la evaluación, no está cubierto por el plan de salud mental (Título 9, Sección 1830.205 (b)(1) CCR).
- ☐ Su condición de salud mental no le ocasiona problemas suficientemente serios en su vida diaria como para que usted sea elegible para recibir servicios de salud mental especializados de su plan de salud mental (Título 9, Sección 1830.205 (b)(2) CCR).
- ☐ No es probable que los servicios especializados de salud mental con los que cuenta su plan de salud le ayuden a mantener o mejorar su condición de salud mental (Título 9, Sección 1830.205 (b)(3)(A) y (B)) CCR).
- ☐ Su condición de salud mental respondería al tratamiento proporcionado por un proveedor de salud física (Título 9, Sección 1830.205 (b)(3)(C) CCR).

Si usted está de acuerdo con la decisión tomada por el plan y le gustaría obtener información sobre cómo encontrar un proveedor fuera del plan para que le diera tratamiento, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

Si usted no está de acuerdo con la decisión tomada por el plan, puede:

Puede pedirle al plan que haga arreglos para tener una segunda opinión sobre su condición de salud mental. Para hacer esto, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilización Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

Puede presentar una apelación a su plan de salud mental. Para servicios para pacientes internos/residenciales, puede llamar o escribir a un representante del Programa de Intercesión a Favor del Paciente al (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para pacientes ambulatorios y para todos los demás servicios de salud mental puede llamar o escribir a un representante del Centro del Consumidor para Intercesión y Educación sobre la Salud al (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101, o seguir las instrucciones en el folleto de información que le entregó el plan de salud mental. Usted debe presentar la apelación dentro de los 90 días posteriores a la fecha de este aviso. En la mayoría de los casos el plan de salud mental debe tomar una decisión sobre su apelación dentro de los 45 días posteriores a su solicitud. Si usted piensa que un retraso podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad de adquirir, mantener o recuperar funciones vitales importantes, entonces puede solicitar una apelación expedita, en la que la decisión debe tomarse en un período de tres días hábiles.

Si tiene preguntas acerca de este aviso, para servicios para pacientes internos/residenciales, puede llamar o escribir a un representante del Programa de Intercesión a Favor del Paciente al (800) 479-2233, 2710 Adams Avenue, San Diego, CA 92116. Para pacientes ambulatorios y para todos los demás servicios de salud mental puede llamar o escribir a un representante del Centro del Consumidor para Intercesión y Educación sobre la Salud al (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101

Si no esta satisfecho con el resultado de su apelación, usted puede solicitar una Audiencia Imparcial del Estado. Al reverso de este formulario se explica cómo solicitar una audiencia.

NOA-A (DMH revised 6/1/05. SD update 1/01/09.)

SUS DERECHOS A TENER UNA AUDIENCIA

Sólo tiene 90 días para solicitar una audiencia. Los 90 días comienzan, ya sea:

1. El día después de que personalmente le entregamos este aviso de la decisión a la apelación de salud mental, **O**
2. El día después de la fecha en el matasellos de este aviso de la decisión a la apelación de salud mental.

Audiencias Expeditas del Estado

Generalmente tarda 90 días a partir de la fecha de su solicitud para tomar una decisión sobre la audiencia. Si piensa que esperar por ese período de tiempo podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad para adquirir, mantener o recuperar funciones vitales importantes, usted puede solicitar una audiencia expedita del estado. **Para solicitar una audiencia expedita, por favor marque la primera casilla en la columna del lado derecho de esta página, bajo el título SOLICITUD DE AUDIENCIA, e incluya la razón por la que está solicitando una audiencia expedita.** Si su solicitud para una audiencia expedita es aprobada, la decisión para la audiencia será emitida dentro de los tres días hábiles siguientes a la fecha en que la División de Audiencias del Estado (*State Hearings Division*) haya recibido su solicitud.

Para conservar los mismos servicios que está recibiendo mientras espera por la audiencia

- Usted debe solicitar la audiencia dentro de los 10 primeros días a partir de la fecha en que se le envió por correo la decisión del plan de salud mental o de la fecha en que se le entregó personalmente; o antes de la fecha efectiva del cambio de servicios, lo que ocurra después.
- Sus servicios de salud mental de Medi-Cal seguirán siendo los mismos hasta que en la audiencia se tome una decisión en contra suya, usted retire su solicitud para una audiencia, o el período de tiempo o los límites de servicio para sus servicios actuales expire, lo que suceda primero.

Reglamentos estatales disponibles

Los reglamentos estatales, incluyendo aquellos que cubren audiencias estatales, están a su disposición en la oficina local de prestaciones de bienestar social (*welfare*) del condado.

Para obtener ayuda

Usted puede obtener ayuda legal gratuita en su oficina local de asistencia legal o a través de otros grupos. Para problemas relacionados con servicios de salud mental residenciales o de pacientes hospitalizados, llame a l programa de call JFS Patient Advocacy Program at 800-479-2233. Para problemas con pacientes ambulatorios y para todos los otros servicios de salud mental llame al número de teléfono gratuito del Consumer Center for Health Education and Advocacy at 877-734-3258. Puede preguntar acerca de sus derechos de audiencia o sobre la asistencia legal gratuita del *Public Inquiry and Response Unit* (Unidad de Preguntas y Respuestas al Público):

Llame gratuitamente al: 1-800-952-5253

Si usted es sordo y usa la línea TDD, llame al: 1-800-952-8349

Representante autorizado

Usted puede representarse a sí mismo en la audiencia del estado. También puede ser representado por un amigo, un abogado o por cualquier persona que usted elija. Usted debe hacer los arreglos para que lo representen.

Aviso de la ley sobre prácticas de información (Sección 1798, et. seq. del Código Civil de California).

La información que se le pide que proporcione en este formulario es necesaria para procesar su solicitud de audiencia. El proceso puede retrasarse si la información no está completa. La División de Audiencias del Estado del Departamento de Servicios Sociales abrirá un expediente de su caso. Usted tiene derecho a examinar los materiales que componen el expediente para la decisión y puede localizar dicho expediente contactando a la Unidad de Preguntas y Respuestas al Público (a los números de teléfono anteriores). Cualquier información que usted proporcione podría ser compartida con el plan de salud mental, los Departamentos Estatales de Servicios de Salud y de Servicios de Salud Mental y con el Departamento de Servicios Humanos y de Salud de los Estados Unidos. (Autoridad: Sección 14100.2 del Código de Instituciones y Prestaciones de Bienestar Social.)

CÓMO SOLICITAR UNA AUDIENCIA DEL ESTADO

La mejor forma de solicitar una audiencia del estado es completando esta página. Saque una copia del frente y del reverso para conservar como constancia. Después envíe esta página a:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Otra forma de solicitar una audiencia es llamando al 1-800-952-5253
Si usted es sordo y usa TDD, llame al 1-800-952-8349

SOLICITUD DE AUDIENCIA

Deseo una audiencia debido a la acción tomada por el Plan de Salud Mental del Condado de San Diego en relación con Medi-Cal.

☐ Marque aquí si desea una audiencia expedita del estado y explique la razón de su solicitud a continuación.

La razón por la que deseo una audiencia expedita es: _____

☐ Si necesita más espacio marque aquí y añada una página.

Mi nombre: (letra de imprenta) _____

Mi número de Seguro Social: _____

Mi domicilio: (letra de imprenta) _____

Mi número de teléfono: (_____) _____

Mi firma: _____

Fecha: _____

Necesito de los servicios de un intérprete sin costo para mí. Mi idioma o dialecto es: _____

Deseo que la persona nombrada a continuación me represente en esta audiencia. Autorizo a dicha persona a que vea mi expediente y a que acuda a la audiencia por mí.

Nombre _____

Domicilio _____

Número de teléfono: _____

Quận Hạt San Diego
Chương Trình Dịch Vụ Sức Khỏe Tâm Thần của Chuyên Ngành Medi-Cal
BẢNG THÔNG BÁO
(Sự Giám Định)

Ngày tháng _____

Kính gửi _____, Thẻ Medi-cal số _____

Sau khi giám định tình trạng sức khỏe tâm thần của quý vị, Chương trình sức khỏe tâm thần Quận hạt San Diego nhận thấy tình trạng của quý vị không hội đủ tiêu chuẩn cần thiết để có quyền hưởng dịch vụ tâm thần qua chương trình của chúng tôi..

Thep ý kiến của của chương trình sức khỏe tâm thần, tình trạng sức khỏe tâm thần của quý vị không hội đủ tiêu chuẩn y tế cần thiết để được trả tiền theo Luật Title 9 của tiểu bang, California Code of Regulations (CCR), Phần 1830.205, vì những lý do sau đây::

- ☐ Sau khi giám định, tình trạng sức khỏe tâm thần của quý vị được xác nhận là không đủ tiêu chuẩn hưởng chương trình sức khỏe tâm thần (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(1)).
- ☐ Tình trạng sức khỏe tâm thần của quý vị không gây cản trở nghiêm trọng trong đời sống hàng ngày để quý vị có thể hội đủ điều kiện nhận dịch vụ sức khỏe tâm thần đặc biệt của chúng tôi (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(2)).
- ☐ Các dịch vụ sức khỏe tâm thần gần như không hiệu quả gì cho quý vị trong việc duy trì và cải tiến tình trạng sức khỏe tâm thần của quý vị (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(3)(A) và (B)).
- ☐ Tình trạng sức khỏe tâm thần của quý vị có thể có hiệu quả nếu đi khám bác sĩ chăm sóc sức khỏe tổng quát (Luật Title 9, California Code of Regulations, Phần 1830.205(b)(3)(C)).

Nếu quý vị đồng ý với sự quyết định này, và muốn biết thêm chi tiết về việc tìm bác sĩ bên ngoài chương trình, quý vị có thể gọi điện thoại và thảo luận với người đại diện chương trình sức khỏe tâm thần của quý vị ở số (800) 479-3339 hay viết thư cho: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

Nếu quý vị không đồng ý với quyết định của chương trình, quý vị có thể làm một hay những điều sau đây:

Quý vị có quyền yêu cầu chương trình sắp xếp để xin ý kiến thứ hai về tình trạng sức khỏe tâm thần của quý vị. Để làm việc này, quý vị có thể gọi và thảo luận với người đại diện chăm sóc sức khỏe tâm thần của quý vị ở số (800) 479-3339 hay viết thư cho: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

Quý vị có thể mở hồ sơ khiếu nại với chương trình sức khỏe tâm thần. Với bệnh nhân đang nằm bệnh viện/hay dịch vụ tại gia, quý vị có thể gọi điện thoại và thảo luận hay viết thư cho người đại diện của chương trình Bệnh Vực Quyền Lợi JFS ở số (800) 479-2233, 2710 Adams, San Diego, CA 92116. Với bệnh nhân ngoại viện và tất cả những dịch vụ sức khỏe tâm thần, quý vị có thể gọi thảo luận hay viết thư cho người đại diện của Trung Tâm Tiêu Thụ về Giáo Dục Sức Khỏe và Bệnh Vực Quyền Lợi (Consumer Center for Health Education and Advocacy) ở số (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. Hay quý vị có thể làm theo sự hướng dẫn viết trong quyền chỉ dẫn sức khỏe tâm thần mà quý vị đã nhận. Quý vị phải mở hồ sơ khiếu nại trong vòng 90 ngày tính từ ngày nhận được thông báo này. Hầu hết các trường hợp, chương trình sức khỏe phải giải quyết trong vòng 45 ngày từ khi quý vị yêu cầu. Quý vị có thể yêu cầu một phiên xử để giải quyết sớm hơn bình thường, có nghĩa là vấn đề sẽ được giải quyết trong vòng 3 ngày làm việc nếu quý vị tin là sự trễ nãi sẽ khiến tình trạng bệnh tâm thần của mình trở nên trầm trọng, bao gồm việc ảnh hưởng không tốt đến khả năng duy trì hay hồi phục chức năng quan trọng của đời sống.

Nếu quý vị có câu hỏi liên quan đến thông báo này, với bệnh nhân nằm viện/ dịch vụ tại gia, quý vị có thể gọi thảo luận hay viết thư cho người đại diện của Chương Trình Bệnh vực Bệnh nhân của JFS ở số (800) 479-2233, 2710 Adams, San Diego, CA 92116. Với bệnh nhân ngoại viện và tất cả những dịch vụ sức khỏe tâm thần khác, xin quý vị gọi thảo luận hay viết cho người đại diện của Trung Tâm Tiêu Thụ về Giáo dục Sức Khỏe và Bệnh vực Quyền lợi (Consumer Center for Health Education and Advocacy) ở số (877) 734-3258, 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101.

If you are dissatisfied with the outcome of your appeal, you may request a State Fair Hearing. The other side of this form will explain how to request a hearing.

QUYỀN ĐIỀU TRẦN

Quý vị chỉ có 90 ngày để yêu cầu buổi điều trần. 90 ngày bắt đầu:

1. Tính từ ngày chúng tôi đích thân đưa quý vị bản thông báo khiếu nại sức khỏe tâm thần này, HAY
2. Tính từ ngày dấu bưu điện in trên bản thông báo khiếu nại sức khỏe tâm thần này.

Buổi Điều trần Nhanh Chóng cấp Tiểu bang

Thường mất 90 ngày kể từ ngày quý vị yêu cầu. Nếu quý vị nghĩ thời gian này có thể gây nguy hại trầm trọng cho sức khỏe tâm thần của mình gồm việc duy trì và phục hồi các chức năng quan trọng của đời sống, quý vị có thể xin được xử nhanh hơn thường lệ. **Để có một buổi điều trần nhanh, xin vui lòng đánh dấu ô đầu tiên bên phải của trang này dưới chữ YÊU CẦU ĐIỀU TRẦN và ghi cả nguyên nhân yêu cầu được xử nhanh.** Nếu lời yêu cầu của quý vị được chấp nhận, người ta sẽ thông báo cho quý vị biết trong vòng ba ngày làm việc tính từ ngày Ủy Ban Điều Trần Tiểu bang nhận khiếu nại của quý vị.

Để được nhận cùng dịch vụ trong khi quý vị chờ đợi buổi Điều trần

- Quý vị phải yêu cầu có buổi điều trần trong vòng 10 ngày tính từ ngày bản thông báo khiếu nại sức khỏe tâm thần gửi đến hay được giao tận tay cho quý vị trước ngày thay đổi dịch vụ, tính theo việc nào xảy ra trễ hơn.
- Các dịch vụ sức khỏe tâm thần Medi-Cal sẽ vẫn giữ nguyên cho đến khi có quyết định cuối cùng của buổi điều trần và nếu kết quả bất lợi cho quý vị, và quý vị thu hồi lời yêu cầu, hay cho đến khi thời hạn nhận dịch vụ bị hết hạn, tính theo việc nào đến trước.

Các Luật Điều Hành Cấp Tiểu Bang

Luật điều hành tiểu bang, bao gồm tin tức điều trần đều có sẵn trong văn phòng trợ cấp xã hội của quận hạt địa phương.

Để được giúp đỡ

Quý vị có thể nhận được sự giúp đỡ pháp lý từ văn phòng trợ giúp pháp lý địa phương hay từ các nhóm khác. Về các vấn đề khó khăn với bệnh nhân nội trú hay các dịch vụ sức khỏe tâm thần tại gia, hãy gọi Chương trình Bệnh vực Bệnh nhân JFS ở số 800-479-2233. Về các vấn đề khó khăn với bệnh nhân ngoại viện và các dịch vụ sức khỏe tâm thần khác, hãy gọi số miễn phí đến Trung tâm Tiêu thụ Giáo dục Sức khỏe và Bệnh vực quyền lợi (Consumer Center for Health Education and Advocacy) ở số 877-734-3258. Quý vị có thể yêu cầu tin tức về quyền xin điều trần hay giúp đỡ pháp lý từ Public Inquiry and Response Unit:

Gọi số miễn phí : 1-800-952-5253

Nếu khiếm thính, gọi TDD, call: 1-800-952-8349

Người đại diện hợp pháp

Quý vị có thể tự điều trần trước phiên xử. Quý vị cũng có thể chọn một người bạn, một luật sư hay bất cứ ai đại diện cho mình. Quý vị phải tự mình sắp xếp việc này

Thông báo của Practices Act Notice (California Civil Code Section 1798, et seq.) Chi tiết mà quý vị được yêu cầu viết trong mẫu này rất cần thiết để xúc tiến buổi điều trần của quý vị. Việc xúc tiến có thể trễ nãi nếu chi tiết không đầy đủ. Hồ sơ sẽ được thiết lập bởi Bộ Xã Hội Tiểu bang, Bộ phận Điều trần. Quý vị có quyền tham khảo hồ sơ và biết nó ở đâu bằng cách liên lạc với Public Inquiry and Response Unit (điện thoại đã ghi bên trên). Bất

cứ chi tiết nào mà quý vị cung cấp, chúng tôi sẽ chia sẻ với chương trình sức khỏe tâm thần, với Bộ Dịch vụ Y tế và Sức Khỏe Tâm thần Tiểu bang và với Bộ Y tế và Nhân sinh của Liên bang (Authority: Welfare and Institutions Code, Section 14100.2)

CÁCH YÊU CẦU BUỔI ĐIỀU TRẦN CẤP TIỂU BANG

Cách hay nhất để yêu cầu được buổi điều trần là điền vào mẫu này. Làm bản sao phần trước và sau của mẫu này để lưu giữ vào hồ sơ của quý vị. Sau đó gửi trang này về:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Một cách khác để xin buổi điều trần là gọi điện thoại số 1-800-952-5253. Nếu quý vị bị khiếm thính thì dùng TDD, gọi số 1-800-952-8349.

YÊU CẦU ĐIỀU TRẦN

Tôi muốn có một buổi điều trần liên hệ đến Medi-Cal và Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego.

☐ Đánh dấu trong ô này nếu quý vị muốn có một buổi điều trần nhanh chóng và viết nguyên nhân tại sao :.

Nguyên nhân:

☐ Đánh dấu vào ô này nếu muốn viết thêm một trang nữa.

Tên họ (chữ in) _____

Số An sinh xã hội: _____

Địa chỉ (chữ in) _____

Điện thoại: (_____) _____

Chữ ký: _____

Ngày tháng: _____

Tôi cần một thông dịch viên miễn phí. Ngôn ngữ gốc của tôi là _____

Tôi muốn người có tên dưới đây đại diện tôi trong buổi điều trần. Tôi cho phép người này xem hồ sơ của tôi và đến dự buổi điều trần cùng tôi.

Tên họ: _____

Địa chỉ: _____

Điện thoại: (_____) _____

Condado de San Diego
Programa de Servicios Especializados de Salud Mental de Medi-Cal
AVISO DE ACCIÓN

Fecha: _____

Para: _____ Número de Medi-Cal: _____

El plan de salud mental del Condado de San Diego ha ☐ negado ☐ cambiado la solicitud de su proveedor por el pago del siguiente(s) servicio(s):

La solicitud fue hecha por: (nombre del proveedor) _____

La solicitud original de su proveedor tenía fecha del _____.

El plan de salud mental tomó esta acción basándose en la información de su proveedor por la razón que se marca a continuación:

- ☐ Su condición de salud mental no cumple con el criterio de necesidad médica para recibir servicios como paciente internado en un hospital psiquiátrico ni para servicios profesionales relacionados (Título 9, Sección 1830.205 del Código de Regulaciones de California (CCR))
- ☐ Su condición de salud mental no cumple con el criterio de necesidad médica para recibir servicios de salud mental especializados que no sean servicios de hospital psiquiátrico como paciente internado, por la siguiente razón (Título 9, Sección 1830.205, CCR): _____
- ☐ El servicio que se solicita no está cubierto por el plan de salud mental (Título 9, Sección 1830.205, CCR).
- ☐ El plan de salud mental solicitó información adicional de su proveedor, la cual necesita para aprobar el pago del servicio propuesto. Hasta la fecha no se ha recibido dicha información.
- ☐ El plan de salud mental pagará por el/los siguientes servicios, en lugar de por los servicios solicitados por su proveedor, basándose en la información disponible sobre sus necesidades de servicio y su condición de salud mental:

- ☐ Otra _____

Si no está de acuerdo con la decisión tomada por el plan, usted puede:

1. Presentar una apelación a su plan de salud mental. Para hacer esto, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370 o seguir las instrucciones en el folleto de información que le entregó el plan de salud mental. Usted debe presentar la apelación dentro de los 90 días posteriores a la fecha de este aviso. En la mayoría de los casos el plan de salud mental debe tomar una decisión sobre su apelación dentro de los 45 días posteriores a su solicitud. Si piensa que un retraso podría ocasionar serios problemas a su salud mental, como problemas relacionados con su capacidad para adquirir, mantener o recuperar funciones vitales importantes entonces usted puede solicitar una apelación expedita, en la que la decisión debe tomarse en un período de tres días hábiles. Usted puede solicitar que sus servicios continúen igual hasta que se tome la decisión a su apelación. Para mantener sus servicios usted debe presentar la apelación dentro de los 10 primeros días a partir de la fecha de este aviso o antes de la fecha en que el cambio de servicios sea efectivo, lo que suceda después. Los servicios solicitados fueron previamente aprobados por el plan, por el período de _____. La fecha efectiva para el cambio de estos servicios es: _____
2. Solicitar una audiencia del estado si no está satisfecho(a) con el resultado a su apelación, lo que permitiría que usted siguiera recibiendo servicios mientras espera por dicha audiencia. Al reverso de este formulario se explica cómo solicitar la audiencia. Usted puede solicitar que sus servicios continúen igual hasta que se tome la decisión a su apelación. Para conservar sus servicios debe presentar la apelación dentro de los 10 primeros días a partir de la fecha de este aviso o antes de la fecha en que los cambios de servicios sean efectivos, lo que suceda después. Los servicios solicitados fueron previamente aprobados por el plan, por el período de _____. La fecha efectiva para el cambio de estos servicios es: _____ Los servicios pueden continuar mientras espera la resolución de su audiencia.
3. Puede pedirle al plan que haga arreglos para tener una segunda opinión sobre su condición de salud mental. Para hacer esto, puede llamar y hablar con un representante de su plan de salud mental al (800) 479-3339 o escribir a: Utilization Management, United Behavioral Health, P. O. Box 601370, San Diego, CA 92160-1370.

Quận Hạt San Diego
Chương Trình Sức Khỏe Tâm Thần Chuyên Ngành Medi-Cal
THÔNG BÁO

Ngày tháng: _____

Kính gửi _____ Thẻ Medi-Cal số _____

Chương Trình Sức Khỏe Tâm Thần của Quận hạt San Diego đã ☐ từ chối ☐ đòi hỏi yêu cầu của cơ quan chăm sóc sức khỏe của quý vị về việc trả tiền các dịch vụ sau đây:

Lời yêu cầu do (tên của của cơ quan chăm sóc sức khỏe) _____

Yêu cầu đầu tiên của cơ quan ghi ngày _____

Chương trình sức khỏe tâm thần quyết định như thế này vì căn cứ vào chi tiết mà cơ quan chăm sóc sức khỏe của quý vị ghi nhận như sau:

- ☐ Tình trạng sức khỏe tâm thần của quý vị không hội đủ tiêu chuẩn cần thiết để hưởng dịch vụ tâm thần cung cấp trong bệnh viện hay các dịch vụ chuyên ngành (Luật Title 9, California Code of Regulations (CCR), Phần 1820.205).
- ☐ Tình trạng sức khỏe tâm thần của quý vị không hội đủ tiêu chuẩn cần thiết để nhận dịch vụ tâm thần chuyên ngành khác hơn là những dịch vụ tâm thần do bệnh viện cung cấp vì những lý do sau đây: (Luật Title 9, CCR, Phần 1830.205): _____
- ☐ Dịch vụ yêu cầu không được chương trình sức khỏe tâm thần trang trải (Luật Title 9, CCR, Phần 1810.345).
- ☐ Chương trình sức khỏe tâm thần yêu cầu cơ quan chăm sóc sức khỏe của quý vị cung cấp thêm chi tiết để chương trình xét và chấp nhận trả tiền các dịch vụ đề nghị. Đến giờ phút này mà chúng tôi vẫn chưa nhận được..
- ☐ Chương trình sức khỏe tâm thần sẽ trả tiền cho những dịch vụ kể dưới đây thay vì dịch vụ do cơ quan chăm sóc sức khỏe của quý vị yêu cầu, căn cứ vào những chi tiết về tình trạng sức khỏe tâm thần và dịch vụ cần thiết của quý vị: _____
- ☐ Những điều khác _____

Nếu quý không đồng ý với quyết định của chương trình, quý vị có thể:

1. Mở hồ sơ khiếu nại với chương trình sức khỏe tâm thần của mình. Để làm việc này, quý vị có thể gọi điện thoại và thảo luận với người đại diện chương trình ở số (800) 479-3339 hay viết thư cho: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370; hay làm theo lời chỉ dẫn trong quyển sách hướng dẫn mà quý vị đã nhận được. Quý vị phải mở hồ sơ khiếu nại trong vòng 90 ngày từ ngày nhận thông báo này. Hầu hết các trường hợp, chương trình sức khỏe tâm thần phải giải quyết khiếu nại của quý vị trong vòng 45 ngày từ lúc quý vị yêu cầu. Quý vị có thể yêu cầu giải quyết nhanh trong vòng ba ngày làm việc, nếu quý vị tin rằng sự giải quyết trễ nãi có thể gây hậu quả nghiêm trọng cho sức khỏe tâm thần, kể cả vấn đề duy trì, hồi phục các chức năng quan trọng của đời sống. Quý vị có thể yêu cầu được nhận dịch vụ cho đến khi có được quyết định của sự khiếu nại. Để giữ được những dịch vụ, quý vị phải mở hồ sơ khiếu nại trong vòng 10 ngày tính từ lúc nhận thông báo này hay trước ngày thay đổi những dịch vụ, tính theo việc nào xảy ra trễ hơn. Những dịch vụ được chương trình chấp nhận trước kia trong khoảng thời gian _____. Sự thay đổi những dịch vụ bắt đầu có hiệu lực từ ngày _____.
2. Nếu quý vị không bằng lòng kết quả của việc khiếu nại, quý vị có thể yêu cầu có một buổi điều trần cấp tiểu bang và quý vị vẫn tiếp tục nhận các dịch vụ trong khi chờ được điều trần. Trang sau của thông báo này có giải thích làm cách nào để xin buổi điều trần. Quý vị có thể yêu cầu giữ những dịch vụ như cũ cho đến khi có kết quả. Để giữ được dịch vụ, quý vị phải mở hồ sơ khiếu nại trong vòng 10 ngày tính từ lúc nhận thông báo này hay trước ngày thay đổi những dịch vụ, tính theo việc nào xảy ra trễ hơn. Những dịch vụ được chương trình chấp nhận trước kia trong khoảng thời gian _____. Sự thay đổi những dịch vụ bắt đầu có hiệu lực từ ngày _____. Các dịch vụ có thể vẫn tiếp tục trong khi quý vị chờ đợi kết quả của buổi điều trần.
3. Quý vị có thể yêu cầu chương trình sắp xếp để có một ý kiến thứ hai về tình trạng sức khỏe tâm thần của quý vị. Để làm việc này, quý vị có thể gọi và thảo luận với một người đại diện của chương trình sức khỏe tâm thần của quý vị ở (800) 479-3339 hay viết thư về: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

Distrito ng San Diego
Programa ng Pinagdalubhasaang Medi-Cal ng mga Serbisyo ng Kalusugang Kaisipan
PAUNANG -SABI NG PAG-GAWA

Petsa: _____

Para kay: _____ Numero ng Medi-Cal _____

Ang panukala ng kalusugang kaisipan para sa Distrito ng San Diego ay ☐ pinagkait ☐ binago sa kahilingan ng iyong tagapagkaloob para sa pagbabayad ng sumusunod na (nga) serbisyo:

Ang kahilingan ay ginawa ni: (pangalan ng taga-pagkaloob) _____

Ang orihinal na kahilingan ng iyong tagapagkaloob ay nakatala sa araw ng _____

Ang panukala ng kalusugang kaisipan ay nakuha ang pag-gawa batay sa inpormasyon ng iyong taga-pagkaloob sa dahilan ay tiyakin sa ibaba :

- ☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat sa pamantayan na kinakailangan ng Medikal para sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama ang pag-gamot sa mga may sakit sa utak o kaugnay ng propesyonal na mga serbisyo (Title 9, California Code of Regulations (CCR), Section 1820.205).
- ☐ Ang kalagayan ng iyong kalusugang kaisipan ay hindi nakasapat ng pamantayan na kinakailangan ng Medikal para sa pinagdalubhasaang serbisyo ng kalusugang kaisipan bukod sa mga serbisyo ng ospital na tumatanggap ng tirahan at pagkain kasama ang pag-gamot sa mga may sakit sa utak para sa mga sumusunod na dahilan (Title 9, CCR, Section 1830.205): _____
- ☐ Ang serbisyo na hinihiling ay hindi napabilang batay sa panukala ng kalusugang kaisipan (Title 9, CCR, Section 1810.345).
- ☐ Ang panukala ng kalusugang kaisipan ay humihiling ng karagdagang inpormasyon na galing sa iyong taga-pagkaloob na ang panukala ay nangangailangan ng pahintulot para sa pagbabayad sa iminungkahing serbisyo. Sa araw na ito, ang inpormasyon ay hindi pa natatanggap.
- ☐ Ang panukala ng kalusugang kaisipan ay siyang magbabayad sa mga sumusunod ng (mga) serbisyo sa halip na hinihiling na serbisyo ng iyong taga-pagkaloob, batay sa nagagamit na inpormasyon ng iyong kalagayan ng kalusugang kaisipan at ang serbisyo na kinakailangan: _____
- ☐ Iba pa: _____

Kung ikaw ay hindi sang-ayon nitong panukalang pasiya, ikaw ay maaring:

1. Ikaw ay maaring magsampa ng panawagan kasama ng iyong panukala ng kalusugang kaisipan. Ang paggawa nito, ikaw ay maaring tumawag at kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370; o sundin ang mga direksyon nasa inpormasyon ng polyeto na ibinigay sa iyo ng panukala ng kalusugang kaisipan . Ikaw ay dapat mag-sampa ng panawagan sa loob ng 90 na araw mula sa petsa nitong paunang-sabi. Karamihan sa mga kalagayan ang panukala ng kalusugang kaisipan ay dapat gumawa ng pasiya ng iyong panawagan sa loob ng 45 na araw ng iyong paghiling. Ikaw ay maaring humiling ng mapabilis na panawagan, na kailangang mapasiyahan sa loob ng 3 gumaganang mga araw, kung ikaw ay naniniwala na pagnaatraso ito ay magiging dahilan ng malubhang mga problema ng iyong kalusugang kaisipan kasama na ang mga problema ng iyong kakayanang makamit, mapanatili, o mabawi ang mahalagang takbo ng buhay. Ikaw ay maaring humiling na ang iyong mga serbisyo ay manatiling walang pagkaiba hanggang ang pasiya ng panawagan ay magawa. Upang manatili ang iyong mga serbisyo kailangan mong magsampa ng panawagan sa loob ng 10 na araw mula sa petsa nitong paunang-sabi o bago ang petsa na mgkabisa ng pagpalit ng serbisyo, alinman ang huli. Ang serbisyo na hinihiling ay dating pinagsang-ayonan ng panukala para sa panahon _____. Ang petsa na magkabisa para sa pagpalit nitong serbisyo ay _____.
2. Kung ikaw ay hindi nasisiyahan sa resulta ng iyong panawagan, ikaw ay maaring humiling ng pormal na paghukom na maaring pahintulutang ipagpatuloy ang mga serbisyo habang ikaw ay naghihintay ng paghukom. Sa kabila nitong paunang-sabi ay nagpaliwanag kung paano humiling ng paghukom. Ikaw ay maaring humiling na ang iyong mga serbisyo ay manatiling walang pagkaiba hanggang ang paghukom ay magawa. Upang manatili ang iyong serbisyo kailangan mong magsampa ng panawagan sa loob ng 10 na araw mula sa petsa nitong paunang-sabi o bago ang petsa na magkabisa ng pagpalit sa serbisyo, alinman ang huli. Ang serbisyo na hinihiling ay dating pinagsang-ayonan ng panukala para sa panahon _____. Ang petsa na magkabisa para sa pagpalit nitong serbisyo ay _____. Ang mga serbisyo ay amaring magpatuloy habang ikaw ay naghihintay sa katatagan ng pasiya ng iyong hukom.
3. Ikaw ay maaring humiling sa panukala na mag-areglo ng pangalawang pagpalagay tungkol sa kalagayan ng iyong kalusugang kaisipan. Ang paggawa nito, ikaw ay maaring tumawag at kausapin ang representante ng iyong panukala ng kalusugang kaisipan sa (800) 479-3339 o sumulat sa: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

مقاطعة سان دييغو
برنامج خدمات الصحة النفسية المتخصصة بالتأمين الصحي الحكومي (Medi-Cal)
بيان إجرائي

التاريخ: _____

إلى: _____ رقم التأمين الصحي الحكومي: _____

إن برنامج الصحة النفسية لمقاطعة سان دييغو قد قرر ☐ رفض طلبك ☐ تغيير طلب موفر الخدمات الخاص بك لدفع تكاليف الخدمات التالية:

تم تقديم الطلب من قبل: (اسم موفر الخدمات) _____

تاريخ الطلب الأصلي المقدم من قبل موفر الخدمات الخاص بك: _____

إن برنامج خدمات الصحة النفسية هذا القرار اعتماداً على البيانات الواردة من موفر الخدمات الخاص بك وذلك للأسباب المبينة أدناه:

☐ إن حالة صحتك النفسية لا تحقق المعايير الطبية الضرورية للحصول على خدمات مستشفى الصحة النفسية السريرية أو الخدمات المتخصصة المتعلقة بالصحة النفسية (المادة 9، CCR، الفقرة 1820.205).

☐ إن حالة صحتك النفسية لا تحقق المعايير الطبية الضرورية للحصول على خدمات الصحة النفسية المتخصصة باستثناء خدمات مستشفى الصحة النفسية السريرية وذلك بسبب (المادة 9، CCR، الفقرة 1830.205): _____

☐ الخدمات المطلوبة غير مشمولة في برنامج الصحة النفسية (المادة 9، CCR، الفقرة 1810.345).

☐ لقد طلب برنامج الصحة النفسية المزيد من المعلومات من موفر الخدمات الخاص بك، يحتاج البرنامج لتلك المعلومات للموافقة على دفع تكاليف الخدمات المطلوبة. لغاية الآن لم يتم إستلام المعلومات المطلوبة.

☐ سيقوم برنامج الصحة النفسية بدفع تكاليف الخدمات التالية بدلاً من الخدمات التي تم طلبها من قبل موفر الخدمات الخاص بك، اعتماداً على المعلومات المتوفرة عن حالة صحتك النفسية و إحتياجك للخدمات.

أخرى: ☐ _____

إن لم توافق على قرار البرنامج فيمكك:

1. يمكنك أن تقدم طلب إستئناف لبرنامج الصحة النفسية الخاص بك. لقيام بذلك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 479-3339 (800) أو براسلة العنوان التالي: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370، أو بإتباع الإجراءات الواردة في كتيب المعلومات الذي قام برنامج الصحة النفسية بإعطائك إياه. يجب أن تقوم بتقديم طلب الإستئناف خلال 90 يوماً من تاريخ هذا البيان. في أغلب الحالات، يجب أن يقوم برنامج الصحة النفسية بإتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به خلال 45 يوماً من تاريخ تقديمك للطلب. يمكنك أن تطلب الحصول على إستئناف مستعجل، و الذي يجب أن يتم إتخاذ قرار بخصوصه خلال 3 أيام عمل، إن كنت تعتقد بأن التأخير قد يؤدي إلى مشاكل جدية على صحتك النفسية، مثل المشاكل المتعلقة بقدرتك على إكتساب أو الحفاظ أو إستعادة بعض وظائف الحياة المهمة. يمكنك أن تطلب الإبقاء على الخدمات التي تحصل عليها حتى يتم إتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به. للإبقاء على الخدمات التي تحصل عليها، يجب أن تقوم بتقديم طلب الإستئناف خلال 10 أيام من تاريخ هذا البيان أو قبل تاريخ نفاذ التغيير في الخدمات، أيهما أبعد. لقد وافق البرنامج من قبل على الخدمات المطلوبة للفترة _____ تاريخ نفاذ التغيير في هذه الخدمات هو _____.

2. إن لم تكن راضياً عن نتيجة الإستئناف، يمكنك أن تطلب الحصول على جلسة إستماع عادلة، ذلك قد يسمح باستمرارك بالحصول على الخدمات أثناء فترة إنتظارك للجلسة. ستبين الصفحة الثانية من هذا البيان كيف يمكنك طلب الحصول على جلسة الإستماع. يمكنك أن تطلب الإبقاء على الخدمات التي تحصل عليها حتى يتم إتخاذ قرار جلسة الإستماع. للإبقاء على الخدمات التي تحصل عليها، يجب أن تقوم بتقديم طلب الإستئناف خلال 10 أيام من تاريخ هذا البيان أو قبل تاريخ نفاذ التغيير في الخدمات، أيهما أبعد. لقد وافق البرنامج من قبل على الخدمات المطلوبة للفترة _____ تاريخ نفاذ التغيير في هذه الخدمات هو _____ قد تستمر بالحصول على الخدمات أثناء إنتظارك لقرار جلسة الإستماع.

3. يمكنك أن تطلب من البرنامج الترتيب للحصول على رأي آخر بخصوص حالة صحتك النفسية. للقيام بذلك، يمكنك الإتصال و التكلم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 479-3339 (800) أو براسلة العنوان التالي: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

مقاطعة سان دييغو
برنامج خدمات الصحة النفسية المتخصصة بالتأمين الصحي الحكومي (Medi-Cal)
بيان إجرائي
(تقييم)

التاريخ: _____

إلى: _____ ، رقم التأمين الصحي الحكومي: _____

قرر برنامج الصحة النفسية في مقاطعة سان دييغو، بعد مراجعة نتائج تقييم حالة صحتك النفسية، بأن حالة صحتك النفسية لا تحقق المعايير الضرورية لتكون مؤهلاً للحصول على خدمات الصحة النفسية المتخصصة ضمن البرنامج.

من وجهة نظر برنامج الصحة النفسية، فإن حالة صحتك النفسية لم تحقق المعايير الطبية الضرورية الواردة في أنظمة الولاية ضمن المادة 9، من قانون الأنظمة في ولاية كاليفورنيا (California Code of Regulations (CCR))، الفقرة 1830.205، وذلك للسبب المؤشر إزاءه أدناه:

☐ إن حالة صحتك النفسية كما تم تشخيصها في عملية التقييم غير مشمولة في خدمات برنامج الصحة النفسية (المادة 9، CCR، الفقرة 1830.205 (ب)). (1).

☐ إن حالة صحتك النفسية لا تسبب لك مشاكل جدية في حياتك اليومية بشكل يجعلك مؤهل للحصول على خدمات الصحة النفسية المتخصصة المقدمة من قبل برنامج خدمات الصحة النفسية (المادة 9، CCR، الفقرة 1830.205 (ب)). (2).

☐ لا يُعتقد بأن خدمات الصحة النفسية المتخصصة المتوفرة لدى برنامج الصحة النفسية ستساعدك على الحفاظ أو تحسين حالة صحتك النفسية (المادة 9، CCR، الفقرة 1830.205 (ب) (3) (أ) و (ب)).

☐ إن حالة صحتك النفسية ستستجيب للعلاج المقدم من قبل موفر خدمات صحية بدنية (المادة 9، CCR، الفقرة 1830.205 (ب) (3) (ج)).

إن وافقت على قرار البرنامج، وكنت ترغب بالحصول على المعلومات المتعلقة بإيجاد موفر خدمات خارج البرنامج للمساعدة على علاج حالتك، يمكنك الإتصال و التكم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 479-3339 (800) أو بمراسلة العنوان التالي: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

إن لم توافق على قرار البرنامج، فيمكنك القيام بأي من الإجراءات التالية:

يمكنك أن تطلب من البرنامج الترتيب للحصول على رأي آخر بخصوص حالة صحتك النفسية. للقيام بذلك، يمكنك الإتصال و التكم مع ممثل عن برنامج الصحة النفسية على الهاتف المرقم 479-3339 (800) أو بمراسلة العنوان التالي: Utilization Management, United Behavioral Health, P.O. Box 601370, San Diego, CA 92160-1370.

يمكنك أن تقدم طلب إستئناف لبرنامج الصحة النفسية الخاص بك. للخدمات السريرية/أو لخدمات الإقامة، يمكنك الإتصال و التكم مع ممثل برنامج الدفاع عن حقوق المرضى (JFS) على الهاتف المرقم 479-2233 (800) أو مراسلته على العنوان التالي 2710 Adams Avenue, San Diego, CA 92116. أما بالنسبة لخدمات العيادة الخارجية و باقي خدمات الصحة النفسية، يمكنك الإتصال و التكم مع ممثل مركز التوعية و التثقيف الصحي للمستهلك على الهاتف المرقم 734-3258 (877) أو مراسلته على العنوان التالي 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. أو يمكنك إتباع التوجيهات الواردة في كتيب المعلومات الذي أعطاك إياه برنامج الصحة النفسية. يجب أن تقوم بتقديم طلب الإستئناف خلال 90 يوماً من تاريخ هذا البيان. في أغلب الحالات، يجب أن يقوم برنامج الصحة النفسية بإتخاذ قرار بخصوص طلب الإستئناف الذي تقدمت به خلال 45 يوماً من تاريخ تقديمك للطلب. يمكنك أن تطلب الحصول على إستئناف مستعجل، و الذي يجب أن يتم إتخاذ قرار بخصوصه خلال 3 أيام عمل، ذلك إن كنت تعتقد بأن التأخير قد يؤدي إلى حصول مشاكل جدية تؤثر على صحتك النفسية، مثل المشاكل المتعلقة بقدرتك على إكتساب أو الحفاظ أو إستعادة بعض وظائف الحياة المهمة.

إن كان لديك إستفسارات بخصوص هذا البيان، للخدمات السريرية/أو لخدمات الإقامة، يمكنك الإتصال و التكم مع ممثل برنامج الدفاع عن حقوق المرضى (JFS) على الهاتف المرقم 479-2233 (800) أو مراسلته على العنوان التالي 2710 Adams Avenue, San Diego, CA 92116. بالنسبة لخدمات العيادة الخارجية و باقي خدمات الصحة النفسية، يمكنك الإتصال و التكم مع ممثل مركز التوعية و التثقيف الصحي للمستهلك على الهاتف المرقم 734-3258 (877) أو مراسلته على العنوان التالي 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. أو يمكنك إتباع التوجيهات الواردة في كتيب المعلومات الذي أعطاك إياه برنامج الصحة النفسية.

إن لم تكن راضياً عن نتيجة الإستئناف، فيمكنك أن تطلب الحصول على جلسة إستماع عادلة على مستوى الولاية. ستبين الصفحة الثانية من هذا البيان كيف يمكنك طلب الحصول على جلسة الإستماع.

Appendix G Quality Improvement Program

**ACTIONS REGARDING
REASONS FOR RECOUPMENT, FY 05-06**

Reason	Adjustment to Cost Report	Service Deletion	Re-entry of service by provider
MEDICAL NECESSITY			
<u>Documentation does not establish:</u>			
An included diagnosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impairment criteria	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proposed intervention to address the impairment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expectation intervention will diminish impairment, prevent significant deterioration, or allow child to progress developmentally	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLIENT/SERVICE PLAN			
Initial plan not completed within time period	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not updated within time period	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No documentation of client participation/agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROGRESS NOTES			
No note for service claimed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Time claimed greater than time documented	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Service provided where ineligible for FFP or in setting subject to lockouts	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (as non-billable)
TBS provided in juvenile hall	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (as non-billable)
Service provided solely academic, vocational, recreation, socialization	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (as non-billable)
Claim for group activity not properly apportioned	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Does not contain signature	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Service provided solely transportation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (as non-billable)
Service provided solely clerical	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (as non-billable)
Service provided solely payee related	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (as non-billable)
"No show" billed (over zero minutes) when no treatment service provided	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> (as InSyst code 299)

APPEAL PROCESS
Medi-Cal QI Recoupment Report
County of San Diego Adult Mental Health Services

Adult Quality Improvement has developed the following 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision.

1. Adult QI Specialist will mail the provider a formal written report outlining the results of their medical record review within 14 days of review completion.
2. Provider has 14 days from date of the cover letter attached to the written report to request a first level appeal.
3. First level appeal must be in writing, specify which recoupment(s) is being appealed, reason why, and include any supporting documentation from the medical record. Appeal should be marked "confidential" and mailed to Victoria Hilton, QI Program Manager.
4. First level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.
5. Should provider disagree with first level decision, provider has 7 working days from receipt of written decision to request a second level appeal. Second level appeal must be in writing, specify which recoupment(s) is being appealed from first level decision, and reason why. Appeal should be marked "confidential" and mailed to Candace Milow, QI Director.
6. Second level appeal decision will be made within 7 working days from receipt of appeal letter. Provider will be informed of this decision in writing.

Mailing address for Adult Quality Improvement:
County of San Diego
Adult Mental Health Services
P.O. Box 85524 Mailstop: P-531G
San Diego, CA 92186-5524

Any questions regarding this procedure may be directed to Victoria Hilton at (619) 563-2747.

**QUALITY IMPROVEMENT – HHSA-MHS
ADULT/OLDER ADULT OUTPATIENT
MEDICATION MONITORING SCREENING TOOL**

*Q.I. Confidential
Information*

*Q.I. Confidential
Information*

Please complete all boxes on this form with legible writing or type

Program:	Psychiatrist:
Client:	Review Date:
Case #:	Reviewer:

	CRITERIA	COMPLIANCE			COMMENTS
		YES	NO	N/A	
1.	Medication rationale and dosage is consistent with community standards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	If labs were indicated, were they ordered, obtained, & acted upon.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Physical health conditions and treatment considered when prescribing psychiatric medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	No more than 2 medications of each chemical class concurrently without a clearly documented rationale.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Adverse drug reactions and/or side effects treated and managed effectively.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	A signed consent form evidences informed consent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Documentation is in accordance with prescribed medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Documentation includes client's:				
8a.	Response to medication therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8b.	Presence/absence of side effects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8c.	Extent of client's adherence with the prescribed medication regime and relevant interventions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8d.	Client's degree of knowledge regarding management of his/her medication(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TOTAL (Please total the YES/NO columns) <i>Please complete a McFloop form if there are any variances.</i>					

Medication Monitoring Committee Minutes

Program Name:		Meeting Date:	
<input type="checkbox"/> Quarter 1 <small>Jul 1 – Sep 30, 20</small>	<input type="checkbox"/> Quarter 2 <small>Oct 1 – Dec 31, 20</small>	<input type="checkbox"/> Quarter 3 <small>Jan 1 – Mar 31, 20</small>	<input type="checkbox"/> Quarter 4 <small>Apr 1 – Jun 30, 20</small>
Screened by: <input type="checkbox"/> County Pharmacy <input type="checkbox"/> MM Committee			

Committee Members

Print Name	Discipline	Sign Name
Chairperson		
Members		

Description of Activities

_____ Total Number of records screened this quarter

_____ Total Number of variances identified

_____ Total Number of McFloops required _____ # Approved/Completed _____ # Outstanding
 (please note that one McFloop form can be completed for one or more variances on a MM Screening Tool)

Please note

The Medication monitoring Submission Form is due 15 days after the end of each quarter (e.g. for first quarter; July, Aug, Sept; report due by Oct. 15) and can be emailed.

Any McFloops that are disapproved must be faxed in.

Do not submit this form or the medication monitoring tools

Please email your Medication Monitoring Submission form to:
QIMatters.hhhsa@sdcounty.ca.gov
Or fax to: (619) 236-1953

Medication Monitoring Feedback Loop Form

(McFloop)

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____

Patient Name _____

Case # _____

Summary of Recommendations/Requests for Action:

Reviewer Signature & Discipline

Date

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

Physician Signature & Discipline

Date

Verification of Physician Response

☐ **Approved**

☐ **Disapproved** (Forwarded to Medical Director)

Reviewer Signature & Discipline

Date

**County of San Diego - Health and Human Services Agency
MONTHLY STATUS REPORT-NOTICE OF ACTION-A**

1. General Information

Contractor Name		Program Type	
Program Name		Provider Type	
Contract Number		Report Period	
RU Number		Date Submitted	
Submitted By		Contact Phone	

2. Notice of Action - Assessment (NOA-A)

[illegible]

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT

*To be completed and submitted via FAX to Quality Improvement Department
within 72 hours of occurrence of incident*

Client Name: <input type="text"/>		
Client Case Number: <input type="text"/>	DOB: <input type="text"/>	
Mental Health Diagnosis (Use DSM IV Codes) : Axis I (Primary) : <input type="text"/> Axis I (Secondary) : <input type="text"/>		
Provider (Program) Name: <input type="text"/>		
Parent Organization (if any): <input type="text"/>		
Staff Involved: <input type="text"/>		
Date of Incident: <input type="text"/>	Time of Incident: <input type="text"/>	Date reported to Provider: <input type="text"/>
Location where Incident Occurred: <input type="text"/> (Address/Setting)		
Date and Time Incident was reported telephonically to BHS QI: <input type="text"/>		

1. Incident Reviewed (Please check one):

- ☐ Death, excluding natural causes – includes death by suicide
- ☐ Homicide by a client - attempted homicide by a client
- ☐ Suicide attempt resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring medical attention
- ☐ For mental health clients: use of physical restraints (prone or supine)*
- ☐ Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Injurious assault on a client or by a client occurring on the program's premises resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- ☐ Inappropriate staff behavior such as sexual relations with a client, financial exploitation of a client, and/or physical or verbal abuse of a client.
- ☐ Major confidentiality breach (lost or stolen laptop, large number of client files/records accessed, etc.)
- ☐ Other:

CONFIDENTIAL

County of San Diego Behavioral Health Services

Client Name:

☐ **Notification to:** ☐Parent ☐CWS ☐Probation ☐Verbal ☐Written

2. Describe the Serious Incident:

(Include people involved and precipitating factors. Indicate if client was admitted to acute care medical or psychiatric unit and length of stay, if known.)

(Continue on Page 3)

3. Other Behavioral Health Services Client is currently receiving:

(Outpatient, case management, medication management, day treatment/rehabilitation, residential, etc.)

(Continue on Page 3)

4. Current prescribed medication:

Name of prescribing physician:

5. Physical or medical concerns:

Report Completed By:

Date/Time:

Program Manager Signature:

Date/Time:

Contact Email:

Contact Phone:

Date Faxed to County QI:

CONFIDENTIAL
County of San Diego Behavioral Health Services

Client Name:

2. Describe the Serious Incident:

(Include people involved and precipitating factors. Indicate if client was admitted to acute care medical or psychiatric unit and length of stay, if known.)

(Continued from Page 2)

3. Other Behavioral Health Services Client is currently receiving:

(Outpatient, case management, medication management, day treatment/rehabilitation, residential, etc.)

(Continued from Page 2)

FAX #: (619) 236-1953
Quality ImprovementUnit

Serious Incident Report Line: (619) 563-2781

CONFIDENTIAL

County of San Diego Behavioral Health Services

QUALITY IMPROVEMENT SERIOUS INCIDENT REPORT OF FINDINGS

*To be completed and submitted to Quality Improvement Department
within thirty (30) days of occurrence of incident*

Provider (Program) Name:

Name of Client:

Client Case Number:

Date of Incident:

RCA Required? ☐ YES ☐ NO

RCA Completed? ☐ YES ☐ NO

1. Summary of Findings:

(Outline any clinical case conferences, meetings or investigations you conducted. Also attach copies of related newspaper articles, coroners and toxicology reports, etc.)

Continued on Page 2

2. Post Committee Recommendations/Planned Improvements:

Continued on Page 2

Report Completed By:

Date:

Program Manager Signature:

Date:

Contact Email:

Contact Phone:

Date Faxed to County Quality Improvement:

CONFIDENTIAL

County of San Diego Behavioral Health Services

**QUALITY IMPROVEMENT SERIOUS INCIDENT
REPORT OF FINDINGS**

3. Summary of Findings:

(Outline any clinical case conferences, meetings or investigations you conducted. Also attach copies of related newspaper articles, coroners and toxicology reports, etc.)

Continued from Page 2

4. Post Committee Recommendations/Planned Improvements:

Continued from Page 2

QUALITY IMPROVEMENT ACTIVITY

Directions for Root Cause Analysis (RCA)

The goal of the RCA is to identify systemic gaps or failures in systems and processes, not to point fingers or lay blame on individuals. The RCA is not the same as the investigation into the incident, which should be completed prior to the RCA.

Instructions for conducting the RCA:

A Root Cause Analysis (RCA) may be completed for any serious incidents, but must be completed for any incidents of suicide and any major loss of confidential client information.

The RCA worksheet that is attached will provide a structure for completing the RCA.

After identifying the Lead, Facilitator and the Participants of the RCA, schedule at least one meeting for the RCA group to complete the following tasks:

- 1) The first step in completing the worksheet for the RCA is describing the serious incident. Include who was involved, services that were effected, and other details of the incident. It is recommended that the incident being reviewed be written up a flow diagram as part of the process of describing the incident. A flow diagram is very useful in identifying gaps in systems and processes. Ask participants to come to the RCA meeting with a basic description of the incident from their perspective that includes dates and processes involved.
- 2) Next step is to note the participants in the RCA. Participants in the RCA may include those involved in the incident but must include those staff who are knowledgeable about the systems and processes that will be analyzed.
- 3) Next identify the systems and processes that will be analyzed. In general, systems and processes will be those programmatic issues that are defined by policy and procedures. Examples of systems and processes are noted in the worksheet. Not all systems and processes will apply in every case, and there may be others that are not listed on the worksheet that arise in the course of analysis.
- 4) The next step is to break down each system or process into the steps involved – it is helpful to have a workflow diagram for each system or process as this can assist in uncovering gaps.
- 5) Identify findings of gaps found in system or process design, how design of system or process compared to the real event, human factors, equipment factors, controllable environmental factors, and uncontrollable external factors. It can help to think about what the system or process would “ideally” look like even if the ideal does not seem possible.

QUALITY IMPROVEMENT ACTIVITY

6) Identify if the finding is a “root cause” (yes or no). For each finding of root cause an analysis is to be completed. Many findings that are not a root cause themselves have “roots” that may need to be addressed. Using a “fishbone” or Ishakawa diagram can assist in identifying these “hidden roots”.

7)The next step is to note if actions will be taken to address the issues that are identified as a root cause

8) The final element of the RCA is to note Action Plans that will be taken to address any issues that are identified as a root cause. This portion of the RCA delineates the items that are being addressed, the strategies that will be implemented, and the measures that will be used to determine the effectiveness of the plan.

QUALITY IMPROVEMENT ACTIVITY

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: _____

(1) Summary of incident:	(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury)																
(2) Participants:	(List all the participants by position and title {no names} involved in the root cause analysis and action plan. Note the Lead of the RCA and the facilitator.)																
(3) Systems and Processes:	<p>(Note systems and processes that were analyzed to determine proximate causes)</p> <p style="text-align: center;">List of possible systems and processes for review:</p> <table border="0"> <tr> <td>___ Assessment Process</td> <td>___ Risk Assessment Process</td> </tr> <tr> <td>___ Physical Assessment Process</td> <td>___ Reception protocols</td> </tr> <tr> <td>___ Medication Protocols</td> <td>___ Control of medications, storage, access</td> </tr> <tr> <td>___ Staffing resources</td> <td>___ Staff training</td> </tr> <tr> <td>___ Security</td> <td>___ Policies and Procedures</td> </tr> <tr> <td>___ Facility</td> <td>___ Communications with client or family</td> </tr> <tr> <td>___ Care Coordination</td> <td>___ Communications among staff</td> </tr> <tr> <td>___ Availability of information</td> <td></td> </tr> </table> <p>Other: _____</p>	___ Assessment Process	___ Risk Assessment Process	___ Physical Assessment Process	___ Reception protocols	___ Medication Protocols	___ Control of medications, storage, access	___ Staffing resources	___ Staff training	___ Security	___ Policies and Procedures	___ Facility	___ Communications with client or family	___ Care Coordination	___ Communications among staff	___ Availability of information	
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___ Physical Assessment Process	___ Reception protocols																
___ Medication Protocols	___ Control of medications, storage, access																
___ Staffing resources	___ Staff training																
___ Security	___ Policies and Procedures																
___ Facility	___ Communications with client or family																
___ Care Coordination	___ Communications among staff																
___ Availability of information																	

QUALITY IMPROVEMENT ACTIVITY

(3) Note each Process to be considered for review and definition	(4) What are the steps in the process as designed? (A flow diagram is recommended)	(5) Findings	(6) Root Cause?		(7) Take Action?
			Yes	No	

QUALITY IMPROVEMENT ACTIVITY

(8) Action Plan		
(a) List of Action Items	(b) Risk reduction strategies	(c) Measures of Effectiveness
Action item 1:		
Action Item 2:		
Action item 3:		
Action item 4:		
Etc...as needed		

QUALITY IMPROVEMENT ACTIVITY

SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

Date and Time of Serious Incident: ___Aug 1, 2010_____

<p>(1) Summary of incident:</p>	<p>(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury)</p> <p>Client, A.N.O.N, committed suicide Friday night at approximately 9:30 PM. Last appointment at clinic Wednesday for meds support, but client missed appointment. Client came in on Friday to see therapist but Receptionist, told client that therapist was on vacation and tried to set up an appointment the following week. No outside parties or witnesses. Client stepped in front of train. Paramedics were called to the scene</p>																
<p>(2) Participants:</p>	<p>(List all the participants by position and title {no names} involved in the root cause analysis and action plan)</p> <table border="0"> <tr> <td>Program Manager</td> <td>Supervisor of Clerical Staff</td> </tr> <tr> <td>Lead Therapist</td> <td>Therapist</td> </tr> <tr> <td>Director of Clinical Operations</td> <td>Doctor</td> </tr> <tr> <td>Receptionist</td> <td></td> </tr> </table>	Program Manager	Supervisor of Clerical Staff	Lead Therapist	Therapist	Director of Clinical Operations	Doctor	Receptionist									
Program Manager	Supervisor of Clerical Staff																
Lead Therapist	Therapist																
Director of Clinical Operations	Doctor																
Receptionist																	
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QUALITY IMPROVEMENT ACTIVITY

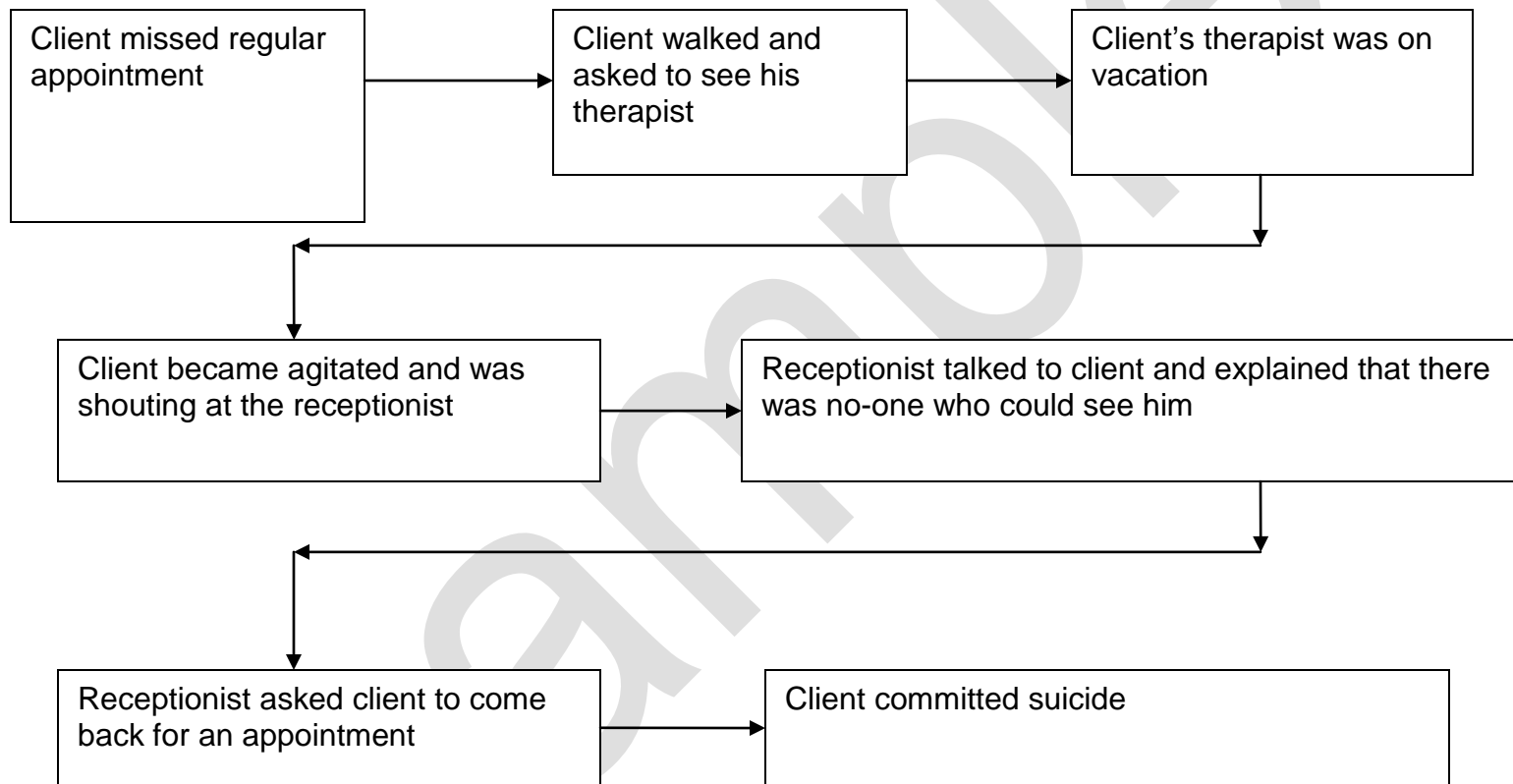
(3) Note each Process to be considered for review and definition	(4) What are the steps in the process as designed? (A workflow diagram is recommended)	(5) Findings	(6) Root Cause?		(7) Take Action?
			Yes	No	
Medication Protocols- Missed Appointment	When a client misses a meds appointment, nurse is to review client record for potential problems with meds	Record was reviewed and protocol for following missed appointment was followed		x	
Reception Protocols- Agitated client	When a client, whose therapist or MD is on vacation or sick, walks in to ask for an urgent appointment reception should contact another therapist to talk with client	Policy is not standardized and there is no current process to have an assigned triage staff on duty.	x		Develop action plan to ensure new policy is drafted and triage process established
Staffing Resources- Therapist on vacation	When a therapist is on vacation a back up system is implemented for all high risk clients	Back up system was implemented, but back up therapist was out sick when client came in.	x		Improve communications (see below)
Risk Assessment Process- High Risk Client	High risk clients are identified and all program staff are aware of potential problems. (see sample workflow)	Process was not followed due to MIS being down.	x		Develop action plan to brainstorm solutions
Staff Training- receptionist	Receptionists shall receive training on how to work with consumers who may be agitated when they come in	Receptionist was not trained as regular trainer is out on maternity leave.	x		Develop action plan to ensure training

QUALITY IMPROVEMENT ACTIVITY

(8) Action Plan		
(a) List of Action Items	(b) Risk reduction strategies	(c) Measures of Effectiveness
Action item 1: Develop action plan to ensure new policy is drafted	Draft new policy about coverage to sick days and vacation days. Train all staff	Track number of clients seen by back up when regular therapist/MD is on vacation or sick. Ask clients how satisfied they were with that services
Action Item 2: Establish triage process	Develop new process for “daily triage duty” assignments	Number of contacts made by staff on daily triage duty Ask consumers if the triage process helped Note # of further incidents after daily triage duty process developed
Action item 3: Develop action plan to brainstorm solutions for communicating about high risk clients that addresses possible MIS outages	Plan a workgroup to meet and brainstorm solutions. Post new processes or protocols for all staff	Number of incidents that occur for clients designated as high risk clients
Action item 4: Develop action plan to ensure training for receptionists on handling difficult situations	Train more staff to be able to provide the training for receptionists Establish a policy that all receptionists must be trained before their first day	Number of difficult situations at the reception area Outcome of difficult situations

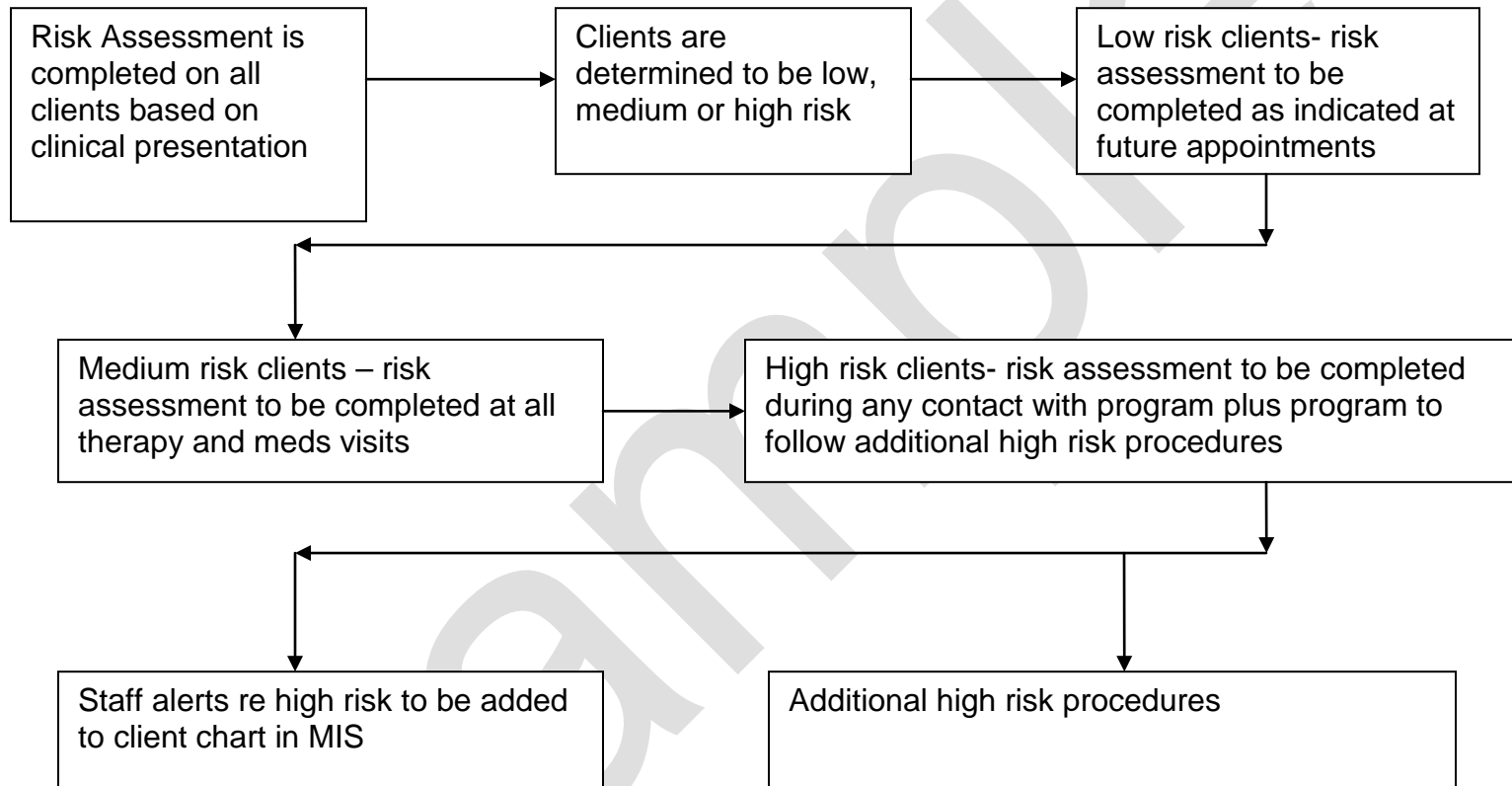
QUALITY IMPROVEMENT ACTIVITY

Workflow for Serious Incident



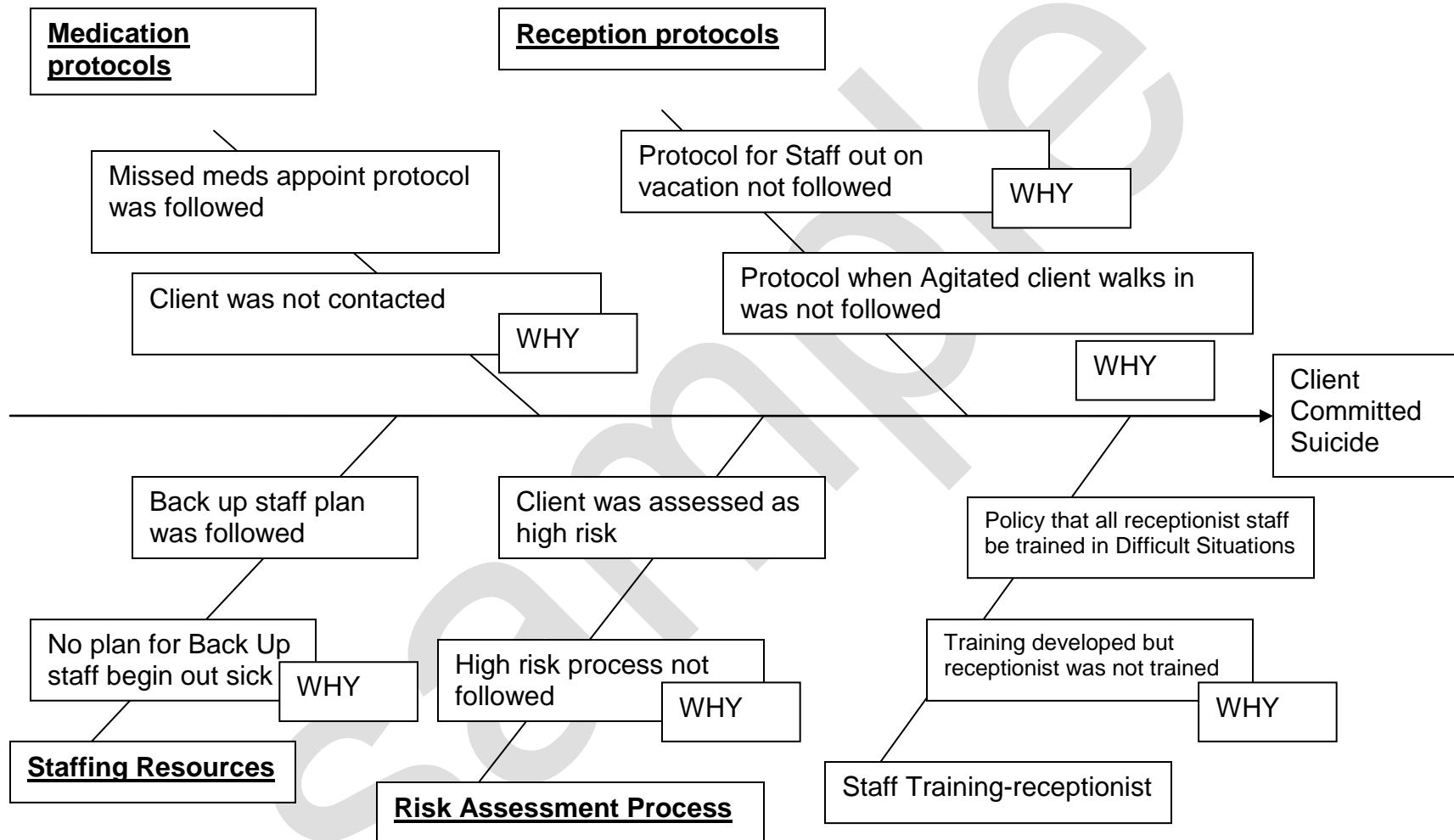
QUALITY IMPROVEMENT ACTIVITY

Workflow for Risk Assessment Process- High Risk Client



QUALITY IMPROVEMENT ACTIVITY

Fishbone Analysis



Adult Medication Monitoring QI Submission Form

Program Name:				Date:			
Unit #		Subunit #					
Report submitted by:				Phone:			
<input type="checkbox"/> Quarter 1 Jul 1 – Sep 30		<input type="checkbox"/> Quarter 2 Oct 1 – Dec 31		<input type="checkbox"/> Quarter 3 Jan 1 – Mar 31		<input type="checkbox"/> Quarter 4 Apr 1 – Jun 30	

Med Mon reports due: Q1: Oct 15 Q2: Jan 15 Q3 : Apr 15 Q4: Jul 15

Description of Activities:

_____ Total number of records screened this quarter

_____ Total number of variances identified

_____ Total number of McFloops required _____ # McFloops Approved/Completed

_____ # McFloops Disapproved _____ # McFloops Outstanding

Disapproved McFloop forms must be faxed in

Total number of variances for all records screened this quarter, listed by item:

1	2	3	4	5	6	7	8a	8b	8c	8d

Email this form to: QIMatters.hhsa@sdcounty.ca.gov

Do not email Med Monitoring Tools

Do not email McFloop Forms

This form may also be faxed to the QI Unit at 619-236-1953

Appendix H Cultural Competence

Culturally Competent Program Annual Self-Evaluation

CC-PAS

Culturally Competent Program Annual Self-Evaluation

The Culturally Competent Program Annual Self-Evaluation (CC-PAS) tool has been developed by San Diego County Mental Health to be used by programs to rate themselves as to their current capability for providing culturally competent services. The CC-PAS Protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC). Once the CC-PAS has been completed programs should use the space at the end of the CC-PAS to develop new or revised objectives the program's Cultural Competence Plan that will support ratings with improved scores during the next rating period.

Directions for scoring for CC-PAS Protocol:

- Review each item and fill out the description as to the status for your program. Add attachments as possible to support your position.
- Determine if your program has Met, Partially Met or Not Met the stated standard using the description of the standard noted for each category.
- Tally the score in each category using the following scale:
 - 5 points for Met Standard
 - 3 points for Partially Met Standard
 - 1 point for Standard Not Met
- Determine the total score.
- If there are certain topics that your program would benefit from having technical assistance you can note that by checking:
 - ____ Technical Assistance needed.
- Keep a record of the results of the CC-PAS to use to evaluate your progress over time.
- Repeat the CC-PAS annually
- Some items may not be applicable if program is not a direct service provider.

CC-PAS Protocol:

- 1) The program/facility has developed a Cultural Competence Plan.
Attach a copy of the Cultural Competence Plan or describe the plan.
-

☐ Met: Program has a written Cultural Competence Plan that addresses the specific needs of that program.

☐ Partially Met: Legal Entity has a written Cultural Competence Plan but the specific needs of that program are not identified or there is no written Cultural Competence Plan but there is some other evidence of a plan.

☐ Not met: There is no plan to achieve Cultural Competence for the program.

Note: QI Unit will supply a format that may be used for developing a Cultural Competence Plan if one is needed

____ Technical Assistance needed

Score = ____

- 2) The program/facility has assessed *the strengths* and needs for services in their community.
Describe the strengths and need for services: _____

☐ Met : The strengths and needs of the community are clearly identified in the Cultural Competence Plan. Community members, Program Advisory Groups, and other stakeholders have participated in the identification of the strengths and needs of the community.

☐ Partially Met: The strengths and needs of the community are not clearly identified in the Cultural Competence Plan but there is evidence that the program is aware of the strengths and needs of the community

☐ Not met: The program is not aware of the strengths and needs of the community

____ Technical Assistance needed

Score = ____

- 3) The staff in the program/facility reflects the diversity within the community.
Attach a report that demonstrates the staff and compares the composition of the staff to the community or describe: _____

☐ Met: The diversity of staff in the program closely matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ Partially Met: The diversity of staff in the program somewhat matches the demographics in the community, and there is evidence that this is a goal the program is working to achieve.

☐ Not met: The staff in the program does not closely match the demographics in the community, and there is no evidence that this is a goal the program is working to achieve.

____ Technical Assistance needed

Score = ____

- 4) The program/facility has a process in place for ensuring language competence of direct services staff who identify themselves as bi-or multi –lingual.
Attach or Describe the process: _____

Culturally Competent Program Annual Self-Evaluation 9/2009

- ☐ Met: The program has a policy or written process for testing the language competence of direct services staff who identify themselves as bi- or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met. The program also surveys clients and family members to assure language competence.
- ☐ Partially Met: The program has an informal process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
- ☐ Not met: The program does not have process for testing the language competence of direct services staff who identify themselves as bi or multi –lingual.
- ☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

5) The program/facility has a process in place for ensuring language competence of support services staff who identify themselves as bi or multi –lingual.

Describe the process: _____

- ☐ Met: The program has a policy or written process for testing the language competence of support services staff who identify themselves as bi or multi –lingual. There is training available for any staff who are bi-lingual or who provide interpreter services to ensure that language needs are being met.
- ☐ Partially Met: The program has an informal process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.
- ☐ Not met: The program has no process for testing the language competence of support services staff who identify themselves as bi or multi –lingual.

____ Technical Assistance needed

Score = ____

6) The program/facility supports/provides interpreter training of direct and indirect services staff.

Describe the process: _____

- ☐ Met: The program has evidence that demonstrates interpreter training of direct and indirect services staff
- ☐ Partially Met: There is informal interpreter services training of direct services staff
- ☐ Not met: There has been no interpreter services training of direct services staff

____ Technical Assistance needed

Score = ____

7) The program/facility uses language interpreters as needed.

Describe the use of language interpreters and languages used? _____

- ☐ Met: The program frequently uses language interpreters, and can consistently demonstrate the offer of interpreters in progress notes.
- ☐ Partially Met : The program occasionally uses language interpreters.
- ☐ Not met: The program does not use language interpreters and can not demonstrate the offer of interpreters

____ Technical Assistance needed

Score = ____

Culturally Competent Program Annual Self-Evaluation 9/2009

8) The program/facility has a process in place for assessing cultural competence of direct services/ support services staff.

Describe the process: _____

- ☐ Met: The program/facility has a written/formal process in place for assessing cultural competence of direct services/ support services staff and can demonstrate the results of those assessments. Additionally, the process includes input from clients and family members
- ☐ Partially Met: The program/facility has a process in place for assessing cultural competence of direct services/ support services staff
- ☐ Not met: The program/facility has no process in place for assessing cultural competence of direct services/ support services staff

_____ Technical Assistance needed

Score = _____

9) The program/facility has a process in place for direct services/ support services staff to self assess cultural competence (e.g. California Brief Multi Competence Scale- CBMCS)

Describe the process: _____

- ☐ Met: The program has a requirement at the time staff are hired, and then periodically after hire, for all staff to complete the CMCBS or a similar tool and has evidence of the results of those evaluations. The program uses the evaluation to identify training needs.
- ☐ Partially Met: The program encourages staff to complete the CMCBS or a similar tool.
- ☐ Not met: The program does not support opportunities for staff to complete the CMCBS or a similar tool and has evidence of the results of the those evaluations,

_____ Technical Assistance needed

Score = _____

10) The program/facility has conducted a survey amongst their clients to determine if the program is perceived as being culturally competent.

Describe the results of the survey: _____

- ☐ Met: The program/facility has conducted a survey amongst their clients and their family members to determine if the program is perceived as being culturally competent.
- ☐ Partially Met: The program/facility is using the annual State survey to determine if the program is perceived as being culturally competent
- ☐ Not met: The program/facility is not using any type of survey to determine if the program is perceived as being culturally competent.

_____ Technical Assistance needed

Score = _____

11) The program/facility conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent.

Describe the results of the survey: _____

- ☐ Met: The program/facility has conducted a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent
- ☐ Partially Met: The program/facility uses the annual State survey to determine if the program's clinical services are perceived as being culturally competent

Culturally Competent Program Annual Self-Evaluation 9/2009

☐ Not met: The program/facility does not use a survey amongst their clients to determine if the program's clinical services are perceived as being culturally competent

____ Technical Assistance needed

Score = ____

12) The program utilizes the Culturally Competent Clinical Practice Standards.

Describe how the standards are utilized: _____

☐ Met: The program utilizes the Culturally Competent Clinical Practice Standards and trains all staff and managers at least annually.

☐ Partially Met: The program utilizes the Culturally Competent Clinical Practice Standards but has little or no training.

☐ Not met: The program does not utilize the Culturally Competent Clinical Practice Standards

☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

13) The program/facility supports cultural competence training of direct services staff.

Describe the process: _____

☐ Met: The program/facility supports cultural competence training of direct services staff and 80 to 100% of staff have attended at least 4 hours of training.

☐ Partially Met : The program/facility supports cultural competence training of direct services staff and 50-79% of staff have attended at least 4 hours of training

☐ Not met: The program/facility does not support cultural competence training of direct services staff

____ Technical Assistance needed

Score = ____

14) The program/facility supports cultural competence training of support services staff.

Describe the process: _____

☐ Met: The program/facility supports cultural competence training of support services staff and 80 to 100% of staff have attended at least 4 hours of training.

☐ Partially Met: The program/facility supports cultural competence training of support services staff and 50-79% of staff have attended at least 4 hours of training

☐ Not met: The program/facility does not support cultural competence training of support services staff

____ Technical Assistance needed

Score = ____

15) Services provided are designed to meet the needs of the community.

Describe how the services meet the needs of the community:

☐ Met: Services provided include additional hours, child care, transportation or other options that are targeted to meet the specific community needs.

☐ Partially Met: Services provided include groups that are targeted to meet the specific community needs.

Culturally Competent Program Annual Self-Evaluation 9/2009

☐ Not met: Services provided include do not include options that are targeted to meet the specific community needs.

____ Technical Assistance needed

Score = ____

16) The program has implemented the use of any Evidence Based Practices, or best practice guidelines *appropriate for the populations served*.

Describe the practices: _____

☐ Met: The program has implemented the use of Evidence Based Practices, or best practice guidelines *appropriate for the populations served*

☐ Partially Met: The program has implemented the use of any Evidence Based Practices, or best practice guidelines

☐ Not met: The program has not implemented the use of any Evidence Based Practices, or best practice guidelines

☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

17) The program collects client outcomes *appropriate for the populations served*.

Describe the client outcomes that are collected and how the information is used:

☐ Met: The program collects client outcomes *appropriate for the populations served*

☐ Partially Met: The program collects client outcomes

☐ Not met: The program does not collect client outcomes.

☐ Not applicable if program is not a direct service provider.

____ Technical Assistance needed

Score = ____

18) The program conducts outreach efforts *appropriate for the populations in the community*

Describe the outreach efforts: _____

☐ Met : The program conducts effective and on-going outreach efforts *appropriate for the populations in the community*

☐ Partially Met: The program conducts occasional outreach efforts *appropriate for the populations in the community*

☐ Not met: The program does not conducts outreach efforts.

____ Technical Assistance needed

Score = ____

19) The program is responsive to the variety of stressors that may impact the communities served.

Examples of responsiveness: _____

☐ Met: The program is responsive to the variety of stressors that may impact the communities served and can demonstrate responsiveness.

☐ Partially Met : The program is aware of the variety of stressors that may impact the communities served

Culturally Competent Program Annual Self-Evaluation 9/2009

☐ Not met: The program not aware of stressors that may have an impact on the communities served

____ Technical Assistance needed

Score = ____

20) The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

Examples of commitment: _____

☐ Met: The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

☐ Partially Met: The program reflects its commitment to cultural and linguistic competence in some policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

☐ Not met: The program does not reflects its commitment to cultural and linguistic competence in all policy and practice documents including it's mission statement, strategic plan, and budgeting practices.

____ Technical Assistance needed

Score = ____

After completing all of the items, #'s 1- 20 above, add all the individual scores together to come up with a CC-PAS rating for the program

Total score = _____

New or revised objectives for the programs Cultural Competence Plan:

**California Brief Multicultural Competence Scale
(CBMCS)**

Below is a list of statements dealing with multicultural issues within a mental health context. Please indicate the degree to which you agree with each statement by circling the appropriate number.

	Strongly Disagree	Disagree	Agree
	Strongly Disagree	Disagree	Agree
1. I am aware that being born a minority in this society brings with it certain 4 challenges that White people do not have to face.	1	2	3
2. I am aware of how my own values might affect my client. 4	1	2	3
3. I have an excellent ability to assess, accurately, the mental health needs of 4 persons with disabilities.	1	2	3
4. I am aware of institutional barriers that affect the client. 4	1	2	3
5. I have an excellent ability to assess, accurately, the mental health needs of 4 lesbians.	1	2	3
6. I have an excellent ability to assess, accurately, the mental health needs of 4 older adults.	1	2	3
7. I have an excellent ability to identify the strengths and weaknesses of 4 psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	1	2	3
8. I am aware that counselors frequently impose their own cultural values upon 4 minority clients.	1	2	3
9. My communication skills are appropriate for my clients. 4	1	2	3
10. I am aware that being born a White person in this society carries with it certain 4 Advantages.	1	2	3
11. I am aware of how my cultural background and experiences have influenced my 4 attitudes about psychological processes.	1	2	3
12. I have an excellent ability to critique multicultural research. 4	1	2	3
13. I have an excellent ability to assess, accurately, the mental health needs of men. 4	1	2	3
14. I am aware of institutional barriers that may inhibit minorities from using mental 4 health services.	1	2	3

15. I can discuss, within a group, the differences among ethnic groups (e.g. low 4 socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	1	2	3
16. I can identify my reactions that are based on stereotypical beliefs about different 4 ethnic groups.	1	2	3
17. I can discuss research regarding mental health issues and culturally different 4 populations.	1	2	3
18. I have an excellent ability to assess, accurately, the mental health needs of 4 gay men.	1	2	3
19. I am knowledgeable of acculturation models for various ethnic minority groups. 4	1	2	3
20. I have an excellent ability to assess, accurately, the mental health needs of women. 4.	1	2	3
21. I have an excellent ability to assess, accurately, the mental health needs of 4 persons who come from very poor socioeconomic backgrounds.	1	2	3

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. (2004). Cultural competency Revised: The California Brief Multicultural Competency Scale. *Measurement and Evaluation in Counseling and Development*, 37, 3,163-187.

Organizational Provider Operations Handbook

Appendix I Management Information System

ANASAZI REQUEST FORM (ARF) – MENTAL HEALTH PROGRAMS

MENTAL HEALTH MANAGEMENT INFORMATION SYSTEM (MHMIS)

FAX FORM TO MHMIS UNIT: 858-467-0411

ALL FORMS MUST BE COMPLETE AND TYPED OR THEY WILL BE RETURNED.

[1] USER TYPE REQUEST

- ☐ New User ☐ Modify Current User
 Anasazi Staff ID#
 Citrix Staff ID
- ☐ Terminate User; Termination Date:
 Anasazi Staff ID#
 Citrix Staff ID

[2] PROGRAM INFORMATION

- ☐ County Staff ☐ Non-County Staff
- Program Name:
 LE/Parent Org:
 User Job Title:
 Employment Start Date:

[3] USER INFORMATION

* If Name Change, please use new name below and enter previous name here:

First Name: MI: Last Name: Work Phone: Ext:
 Primary Work Street Address: Last 5 of SSN:
 City: State: Zip: User Work Email:

[4] MENU GROUP None

If Clinical Menu is selected, enter Assessments Training date
 If Data Entry Menu is selected, enter New Hire/Service Entry Training date
 If Scheduler Menu is selected, enter Scheduler training date
 If Program Manager or 24 Hour Menu is selected, enter Assessments and New Hire/Service Entry dates above.

[5] UNIT/SUBUNIT ACCESS (LIST ALL UNITS AND SUBUNITS TO WHICH USER REQUIRES ACCESS)

Unit:	Subunit(s):	Unit:	Subunit(s):
Unit:	Subunit(s):	Unit:	Subunit(s):
Unit:	Subunit(s):	Unit:	Subunit(s):

[6] CREDENTIAL & CERTIFICATION INFORMATION

☐ No Credential – Administrative Staff OR

Select Credential: Unlicensed **None** OR Licensed **None**

License or Registration # state of issuance NPI # TAXONOMY #

If User is a Medicare certified provider, provide PTAN and effective date:

[7] LANGUAGES SPOKEN

Language #1: Language #2: Language #3: Language #4 :

[8] COMMENTS:**[9] PROGRAM CONTACT INFORMATION** (FOR MHMIS QUESTIONS)

First Name: Last Name: Work Email: Phone:

[10] USER ACCESS AUTHORIZATION

User Signature: _____

First Name: Last Name: Date:

Pursuant to the contractual agreement on file with the County of San Diego and as designated by my corporate office, I am authorizing access as noted above and affirm that I have personally reviewed the County's Summary of Policies with the above user.

Authorizing Program Manager Signature: _____

First Name: Last Name: Date:

MHMIS Unit Only: ☐ Anasazi ☐ CSRF ☐ NPI ☐ SESA **EFFECTIVE DATE:** **Staff ID:**



COUNTY OF SAN DIEGO

Summary of Policies Regarding County Data/Information and Information Systems

To aid in the performance of their regular job assignments and duties, County employees, volunteers, agents and contractors are provided access to many County tools and resources. In the electronic age, these tools and resources include County "data/information" in various formats (e.g. on electronic media, paper, microfiche) and County "information systems" (e.g. computers, servers, networks, Internet access, fax, telephones and voice mail), whether owned, provided or maintained by or on behalf of the County.

The County has established policies and procedures based on best business practices to support the performance of the County's business and to protect the integrity, security and confidentiality of the County's data/information and information systems. Users¹ of these resources play a critical role. By carrying out their regular assignments and duties in compliance with all applicable County's policies and procedures, best practices are maintained.

This summary helps users know their responsibilities by highlighting important aspects of policies that govern access to and use of County data/information and information systems. The policies themselves provide further detailed information governing the use of County data/information and information systems and should be reviewed. Most notably, the County Chief Administrative Officer (CAO) Policy *Acceptable Use of County Data/Information* provides additional guidance on protecting County data/information; the CAO Policy *County Information Systems – Management and Use* provides guidance in controlling and using County information systems; and the CAO Policy *Telecommunications – Management and Use* provides guidance in using desktop and cellular telephones.

Access to County data/information or information systems is necessary to the performance of regular assignments and duties. Failure to comply with these policies and procedures may constitute a failure in the performance of regular assignments/duties. Such failure can result in the temporary or permanent denial of access privileges and/or in discipline, up to and including termination, in accordance with Civil Service Rules.

1. County data/information in all formats and information systems are for authorized County use only. Personal use of County information systems is prohibited unless specifically authorized by the Appointing Authority.
2. As part of their regular assignments and duties, users are responsible for protecting any data / information and information systems provided or accessible to them in connection with County business or programs.
3. Users cannot share data/information with others outside of their regular duties and responsibilities unless specifically authorized to do so.
4. Users have no expectation of privacy regarding any data/information created, stored, received, viewed, accessed, deleted or input via County information systems. The County retains the right to monitor, access, retrieve, restore, delete or disclose such data/information.

¹ For purposes of this summary, the term "user" shall refer to any person authorized to use County data/information and information systems to perform work in support of the business, programs or projects in which the County is engaged. It also applies to users accessing other networks, including the Internet, through County information systems.

5. Attempts by users to access any data or programs contained on County information systems for which they do not have authorization will be considered a misuse.
6. Users shall not share their County account(s) or account password(s) with anyone, use another's account to masquerade as that person, or falsely identify themselves during the use of County information systems.
7. The integrity and security of County data/information depends on the observation of proper business practices by all authorized users. Users are requested to report any weaknesses in County information system security and any incidents of possible misuse or violation of County IT policies to the appropriate County representative.
8. Users shall not divulge Dial-up or Dial-back modem phone numbers to anyone.
9. Users shall not make copies of system configuration files (e.g. password files) for their own unauthorized use or to provide to other people/users for unauthorized uses.
10. Users shall not make copies of copyrighted software or information, except as permitted by law or by the owner of the copyright.
11. Users shall not engage in any activity that harasses, defames or threatens others, degrades the performance of information systems, deprives an authorized County user access to a County resource, or circumvents County security measures.
12. Users shall not download, install or run security programs or utilities that reveal or exploit weaknesses in the security of a County information system. For example, County users shall not run password cracking or network scanning programs on County information systems.

Misuse of workplace tools and resources, including County data/information and/or County information systems, will be reported to a user's management. Misuse may constitute a failure to perform regular duties and assignments. Such failure may result in short-term or permanent loss of access to County data/information or information systems and/or disciplinary action in accordance with Civil Service Rules, up to and including termination. For non County employees, including volunteers and employees of County contractors, misuse may result in a suspension or withdrawal of your access rights, termination of your participation in County programs, or appropriate action against the contractor under the contract's terms, or any combination of all or some of the above consequences.

Acknowledgement:

I have received and read the County of San Diego's Summary of Policies Regarding County Data/Information and Information Systems.

Print Name:

Signature:

Date Signed:

Supervisor / Manager / Witness:

Date Signed:

ALL SIGNERS:

COUNTY SIGNERS:

Keep a copy of this summary for your reference

Department Personnel Representative --- file the original of this form in the authorized user's agency or department personnel file.

NON-COUNTY SIGNERS: Contract administrator --- file the original form along with the contract

SAN DIEGO COUNTY MENTAL HEALTH SERVICES

ELECTRONIC SIGNATURE AGREEMENT

This Agreement governs the rights, duties, and responsibilities associated with the use of an electronic signature within the San Diego County Mental Health Services Management Information System.

The undersigned (I) understands that this Agreement describes my obligations to protect my electronic signature, and to notify appropriate authorities if it is compromised. I agree to the following terms and conditions:

I understand that my ability to electronically sign medical records is dependent upon utilization of a unique pass phrase that is assigned solely to me. I agree to keep my pass phrase I use to access my electronic signature secret and secure by taking reasonable security measures to prevent it from being compromised, and to prevent unauthorized disclosure of, access to, or use of it or of any media on which information about it is stored. I understand I may not share it with anyone under any circumstances. I agree that access to my electronic signature may be revoked or terminated per the terms of this agreement.

I will use my electronic signature and unique pass phrase to establish my identity and sign electronic documents and forms completed in the course of carrying out my assigned job duties. I am solely responsible for protecting my electronic signature and the pass phrase that allows me access to sign documents and forms electronically. If I suspect or discover that my electronic signature has been used by an unauthorized party, or otherwise compromised, then I will immediately notify the County Mental Health MIS Unit and request that my pass phrase be de-activated. I will then immediately request the ability to create a new pass phrase to use to access my electronic signature. I will immediately request that my electronic signature be revoked if I discover or suspect that it has been or is in danger of being subjected to unauthorized use in any way. I understand that I may also request revocation at any time for any other reason.

If I have requested that my access to my electronic signature be revoked, or I am notified that someone has requested that my access be suspended or revoked, and I suspect or discover that it has been or may be compromised or subjected to unauthorized use in any way, I will immediately cease using my pass phrase and my electronic signature. I will also immediately cease using my electronic signature upon termination of employment or termination of this Agreement.

I further agree that, for the purposes of authorizing and authenticating electronic health records, my electronic signature has the full force and effect of a signature affixed by hand to a paper document.

Requestor Signature _____ Date_____

Requestor Printed Name _____ Anasazi ID_____

Supervisor Signature _____ Date_____

SAN DIEGO COUNTY MENTAL HEALTH SERVICES

Supervisor Printed Name _____



REASONS FOR RECOUPMENT
FOR FY 2010-2011

NON-HOSPITAL SERVICES

MEDICAL NECESSITY:

1. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1830.205(b)(1)(A-R).

CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R)

2. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning
- A probability the child will not progress developmentally as individually appropriate
- For full-scope Medi-Cal (M/C) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

CCR, Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C) and 1830.210(a)(3)

3. Documentation in the chart does not establish that the focus of the proposed intervention is to address the condition identified in CCR, Title 9, Chapter 11, Section 1830.205(b)(2)(A),(B),(C)-(see below):

- A significant impairment in an important area of life functioning
- A probability of significant deterioration in an important area of life functioning
- A probability the child will not progress developmentally as individually appropriate
- For full-scope Medi-Cal (M/C) beneficiaries under the age of 21 years, a condition as a result of the mental disorder that specialty mental health services can correct or ameliorate

NOTE: EPSDT services may be directed toward the substance abuse disorders of EPSDT eligible children who meet the criteria for specialty mental health services under this agreement, if such treatment is consistent with the goals of the mental health treatment and services are not otherwise available.

REASONS FOR RECOUPMENT FOR FY 2010-2011

CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(A)

4. Documentation in the chart does not establish the expectation that the proposed intervention will do, at least, one of the following:

- Significantly diminish the impairment
- Prevent significant deterioration in an important area of life functioning
- Allow the child to progress developmentally as individually appropriate
- For full-scope Medi-Cal (M/C) beneficiaries under the age of 21 years, correct or ameliorate the condition

CCR, Title 9, Chapter 11, Sections 1830.205(b)(3)(B)(1), (2), and (3)

CLIENT PLAN:

5. Initial client plan was not completed within time period specified in the MHP's documentation guidelines, or lacking MHP guidelines, within 60 days of intake unless there is documentation supporting the need for more time.

MHP Contract, Exhibit A, Attachment 1, Appendix C

6. Client plan was not completed, at least, on an annual basis as specified in the MHP's documentation guidelines.

MHP Contract, Exhibit A, Attachment 1, Appendix C

7. No documentation of client or legal guardian participation in the plan or written explanation of the client's refusal or unavailability to sign as required in the MHP Contract with the DMH.

MHP Contract, Exhibit A, Attachment 1, Appendix C

8. For beneficiaries receiving TBS, no documentation of a plan for TBS.

DMH Letter No. 99-03, Pages 6-7

PROGRESS NOTES:

9. No progress note was found for service claimed.

CCR, Title 9, Chapter 11, Section 1810.440(c); MHP Contract, Exhibit A, Attachment 1, Appendix C

10. The time claimed was greater than the time documented.

CCR, Title 9, Chapter 11, Section 1810.440 (c); MHP Contract, Exhibit A, Attachment 1, Appendix C

REASONS FOR RECOUPMENT **FOR FY 2010-2011**

11. The progress note indicates that the service was provided while the beneficiary resided in a setting where the beneficiary was ineligible for FFP, e.g., Institute for Mental Disease, jail, and other similar settings, or in a setting subject to lockouts per Title 9, Chapter 11.

CCR, Title 9, Chapter 11, Sections 1840.312(g)&(h) and 1840.360-374; CFR, Title 42, Sections 435.1008 and 435.1009; and CCR, Title 22, Section 50273 (1-9)

12. The progress note clearly indicates that the service was provided to a beneficiary in juvenile hall and when ineligible for M/C. (Dependent minor is M/C eligible. Delinquent minor is only M/C eligible after adjudication for release into community).

CFR, Title 42, Section 435.1008 and 435.1009; and CCR, Title 22, Section 50273 (1-9)

13. The progress note indicates that the service provided was solely for one of the following:

- a) Academic educational service
- b) Vocational service that has work or work training as its actual purpose
- c) Recreation
- d) Socialization that consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors

CCR, Title 9, Chapter 11, Section 1840.312(a), (b), (c), and (d)

14. The claim for a group activity was not properly apportioned to all clients present.

CCR, Title 9, Chapter 11, Section 1840.316(b)(2)

15. The progress note does not contain the signature (or electronic equivalent) of the person providing the service.

MHP Contract, Exhibit A, Attachment 1, Appendix C

16. The progress note indicates the service provided was solely transportation.

CCR, Title 9, Chapter 11, Sections 1810.355(a)(2), 1840.312(f), and 1810.247, and 1840.110(a)

17. The progress note indicates the service provided was solely clerical.

CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

18. The progress note indicates the service provided was solely payee related.

CCR, Title 9, Chapter 11, Sections 1840.312(f), and 1810.247, 1840.110(a), and 1830.205(b)(3)

19. No service provided: Missed appointment per DMH Letter No. 02-07

DMH Letter No. 02-07

REASONS FOR RECOUPMENT **FOR FY 2010-2011**

20. For beneficiaries receiving Therapeutic Behavioral Services (TBS), the TBS progress notes overall clearly indicate that TBS was provided solely for one of the following reasons:

- a) For the convenience of the family, caregivers, physician, or teacher
- b) To provide supervision or to ensure compliance with terms and conditions of probation
- c) To ensure the child's/youth's physical safety or the safety of others, e.g., suicide watch
- d) To address conditions that are not a part of the child's/youth's mental health condition

DMH Letter No. 99-03, Page 4

21. For beneficiaries receiving TBS, the progress note clearly indicates that TBS was provided to a beneficiary in a hospital mental health unit, psychiatric health facility, nursing facility, or crisis residential facility.

DMH Letter No. 99-03, Page 5

HOSPITAL SERVICES

MEDICAL NECESSITY:

22. Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1820.205(a)(1)(A-R).

CCR, Title 9, Chapter 11, Section 1820.205(a)(1)(A-R)

23. Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1820.205(a)(1)(A-R), the beneficiary requires psychiatric inpatient hospital services for, at least, one of the following reasons:

- Presence of symptoms or behaviors that represent a current danger to self or others, or significant property destruction
- Presence of symptoms or behaviors that present the beneficiary from providing for, or utilizing food, clothing or shelter
- Presence of symptoms or behaviors that present a severe risk to the beneficiary's physical health
- Presence of symptoms or behaviors that represent a recent, significant deterioration in ability to function
- Need for psychiatric evaluation, medication treatment, or other treatment that can reasonably be provided only if the beneficiary is in a psychiatric inpatient hospital
- Presence of either a serious adverse reaction to medications or the need for procedures/therapies that require continued psychiatric inpatient hospitalization

CCR, Title 9, Chapter 11, Sections 1820.205(a)(2)(B) 1 a-d, 1820.205(a)(2)(B) 2 a-c, and 1820.205(b)(1-4)

REASONS FOR RECOUPMENT
FOR FY 2010-2011

ADMINISTRATIVE DAY:

24. Documentation in the chart does not establish that the beneficiary previously met medical necessity for acute psychiatric inpatient hospital service during the current hospital stay.

CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2)

25. Documentation in the chart does not establish that the hospital made the minimum number of contacts with the non-acute residential treatment facilities as evidenced by a lack of the following:

- a) The status of the placement option(s)
- b) The dates of the contacts, and
- c) The signature of the person making each contact.

CCR, Title 9, Chapter 11, Sections 1820.220(j)(5) and 1820.225(d)(2)

CLIENT PLAN:

26. The beneficiary record does not contain a client plan.

Code of Federal Regulations (CFR), Title 42, Subchapter C, Subpart D, Sections 456.180; CCR, Title 9, Chapter 11, Section 1820.210

27. The client plan was not signed by a physician.

CFR, Title 42, Subchapter C, Subpart D, Sections 456.180; CCR, Title 9, Chapter 11, Section 1820.210

OTHER

28. A claim for a day when the beneficiary was not admitted to the hospital.

CCR, Title 9, Chapter 11, Sections 1810.238, 1820.205 and 1840.110(a); (b)(2)(A),(B),(C) and 1830.210(a)(3)

DISALLOWANCE/DELETION INSTRUCTIONS

Instructions: For each reason, follow the corresponding action identified and document that on the Provider Self Reported Disallowance & Deletion Form. All services identified as disallowances on the Disallowance & Deletion Form will be disallowed from the California State Department of Mental Health Claims Database.

Reason	Disallow Billing	Delete Service	Provider Re-enter Service
Medical Necessity:			
1. Documentation does not establish an included diagnosis	X	Not Deleted	No re-entry for this reason.
2. Documentation does not establish impairment criteria	X	Not Deleted	No re-entry for this reason.
3. Documentation does not establish proposed intervention to address the impairment	X	Not Deleted	No re-entry for this reason.
4. Documentation does not establish expectation intervention will diminish impairment, prevent significant deterioration, or allow child to progress developmentally	X	Not Deleted	No re-entry for this reason.
Client/Service Plan:			
5. Initial plan not completed within time period	X	Not Deleted	No re-entry for this reason.
6. Not updated within time period	X	Not Deleted	No re-entry for this reason.
7. No documentation of client participation/agreement	X	Not Deleted	No re-entry for this reason.
Progress Notes:			
8. No note for service claimed	X	County Fiscal Deletes	No re-entry for this reason.
9. Time claimed greater than time documented	X	County Fiscal Deletes	Re-enter corrected time.
10. Service provided were ineligible for FFP (Federal Financial Participation) or in setting subject to lockouts (i.e. service provided while client was in an IMD, Jail, Juvenile Hall, etc...)	X	County Fiscal Deletes	Re-enter as non-billable.
11. TBS provided in juvenile hall	X	County Fiscal Deletes	Re-enter as non-billable.
12. Service provided was solely academic, vocational, recreation, socialization	X	County Fiscal Deletes	Re-enter as non-billable.
13. Claim for group activity was not properly apportioned	X	County Fiscal Deletes	Re-enter corrected time.
14. Does not contain a signature	X	Not Deleted	No re-entry for this reason.
15. Service provided was solely transportation	X	County Fiscal Deletes	Re-enter as non-billable.
16. Service provided was solely clerical	X	County Fiscal Deletes	Re-enter as non-billable.
17. Service provided was solely payee related	X	County Fiscal Deletes	Re-enter as non-billable.
18. "No Show" billed (over zero minutes) when no treatment service provided	X	County Fiscal Deletes	Re-enter as non-billable.
Data Entry:			
19a. Data Entry Error - The wrong date of service	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19b. Data Entry Error - Wrong Service Indicator	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19c. Data Entry Error - Wrong procedure code	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19d. Data Entry Error - Wrong therapist	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19e. Data Entry Error - Wrong Time Entered	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19f. Data Entry Error - Wrong client	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19g. Data Entry Error - Wrong Unit or Sub-Unit	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19h. Data Entry Error - Wrong episode opening date	Depends on Time	County Fiscal Deletes	Re-enter corrected service.
19i. Data Entry Error - Clinet is absent	Depends on Time	County Fiscal Deletes	No re-entry for this reason.
19j. Data Entry Error - Duplicate Entry	Depends on Time	County Fiscal Deletes	No re-entry for this reason.
Other			
20. Documentation done 14 days after date of service	X	County Fiscal Deletes	Re-enter as non-billable.

PROVIDER SELF REPORT DISALLOWANCE & DELETION FORM (ANASAZI)

For instructions please refer to attached worksheet Disallowance/Deletion Instructions

Organization Name		Email Address	
Program Name		Contact Phone	
Contract Number		Date Submitted	
Unit & Sub-Unit Number	Provider ID	Review Date	
Approved & Submitted By		County Tracking Number	County Review Date

By submitting this form, the organization hereby certifies that all entries are correct and accurate, a thorough review was conducted, and a full understanding that submitted disallowance amounts will be deducted from the organizational account. Organization further certifies that it fully understands and has reviewed the County of San Diego, Health and Human Services Agency, Mental Health Services Organizational Handbook specifically dealing with Billing Disallowances-Provider Self Report.

[illegible]

BEHAVIORAL HEALTH SERVICES
PROPERTY INVENTORY FORM

FISCAL YEAR: _____
COUNTY CONTRACT #: _____
PROGRAM NAME _____
PROGRAM SITE ADDRESS _____
COTR NAME: _____

DATE INVENTORY TAKEN: _____
month/date/year

NEW / RECONCILIATION / REVISION
(CIRCLE ONE whichever is applicable)

SIGNATURE: _____

NAME & JOB TITLE: _____

Yellow County Property Tag/ Label Attached? (Yes/ No)	Description	Qty	Make	Model	Serial #	Acq. Date (Mo/Yr)	Original Cost/Fundi ng Source	Date of Disposal of Fixed Assets or Minor Equipment	Date AUD253 completed

REMARKS:

FORMAL COMPLAINT BY PROVIDER

Provider's Name	
Program Manager	
Agency	
Address	
Phone	
Fax	

[illegible]

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 06/15/10)

(Please fill-in all boxes below. See reverse side for completion instructions.)

APPLICANT'S FULL NAME (Include aliases and maiden names):						
TYPE OF WAIVER REQUEST (Please check appropriate box)						
WITHIN CALIFORNIA/NOT LICENSE ELIGIBLE PSYCHOLOGIST CANDIDATE: (5 years maximum) <input type="checkbox"/>	OUT-OF-STATE/LICENSING-EXAM-READY: (3 years maximum) <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 33%;">PSYCHOLOGIST CANDIDATE <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">LCSW CANDIDATE <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">MFT CANDIDATE <input type="checkbox"/></td> </tr> </table>			PSYCHOLOGIST CANDIDATE <input type="checkbox"/>	LCSW CANDIDATE <input type="checkbox"/>	MFT CANDIDATE <input type="checkbox"/>
PSYCHOLOGIST CANDIDATE <input type="checkbox"/>	LCSW CANDIDATE <input type="checkbox"/>	MFT CANDIDATE <input type="checkbox"/>				
DATE OF COMPLETION OF REQUIRED COURSEWORK:	EMPLOYMENT START DATE (in the position requiring the waiver):					
REQUEST SUBMITTED BY: (SIGNATURE----MENTAL HEALTH DIRECTOR/DESIGNEE)						
PRINTED NAME:						
DATE:	COUNTY:					
DO NOT COMPLETE THE FOLLOWING - FOR STATE DEPARTMENT OF MENTAL HEALTH USE ONLY						
DATE COMPLETE WAIVER APPLICATION RECEIVED:	DATE WAIVER BEGINS:					
COMMENTS:	DATE WAIVER ENDS:					
Approved by: <input type="checkbox"/> Program Administrator, Program Compliance OR <input type="checkbox"/> Chief, Medi-Cal Oversight						
Signature:		Date:				
This waiver is granted pursuant to Welfare and Institutions Code Section 5751.2 and with the stipulation that the employer and the applicant assume responsibility for meeting all applicable statutory and regulatory requirements during the approved waiver period.						

MENTAL HEALTH PROFESSIONAL LICENSING WAIVER REQUEST

MH 12 (Rev 06/15/10)

PROFESSIONAL LICENSING WAIVER REQUEST**Instructions for Completing This Form**

- 1) Applicant's Full Name, Include Aliases and Maiden Names: DMH staff need this information, when applicable, to track accurately the applicant's waiver history.
- 2) Type of Waiver Request: Clearly indicate the type of waiver request. To be eligible for the Out-of-State/License-Ready category, an applicant must be both license-ready and recruited from out-of-State. When submitting an application for an Out-of-State/License-Ready waiver, the MHP must submit a letter from the appropriate licensing board which states that the applicant has sufficient experience to gain admission to the licensing examination.
- 3) Employment Start Date (In the Position Requiring the Waiver): Specify the date the applicant will start employment in the position requiring a waiver.

In order for the DMH to determine if the applicant has been previously employed in a position requiring a waiver, **it is necessary to attach a copy of the applicant's post-degree employment history.** This can take the form of a current, complete resume or recent employment application.
- 4) Request Submitted By (Mental Health Director/Designee): All waiver requests must be submitted, signed and dated by the local county mental health director or the director's designee.

For additional information on the professional licensing waiver process, see DMH Letter No 10-03. .

This procedure applies only to providers approved for MAA Claiming.

Medi-Cal Administrative Activities (MAA) Procedures

MAA activities in mental health are governed by a set of procedures. These procedures are described in detail in the MAA Instruction Manual developed by the State Department of Mental Health, and are summarized below.

The Claiming Plan

In order to participate in MAA, the County must submit a Claiming Plan to the State for approval by the last day of the quarter in which the first invoice will be submitted. Using a standardized format developed cooperatively by the State and Federal Medicaid agencies, the MAA Claiming Plan must describe in detail each of the MAA activities for which claims will be submitted, by job class. The standardized format can be found in the California Department of Mental Health MAA instruction manual.

The Claiming Plan also describes the units that will be participating in MAA, the type of supporting documentation that will be maintained, and the development and documentation of costs relating to MAA. It indicates which activities will be focused entirely on the Medi-Cal population. If the activities will be focused on a larger population, the Claiming Plan must describe the methodology that will be used to discount the claim by the percentage of Medi-Cal eligibles in the population.

The State Department of Mental Health has established procedures for amending the MAA Claiming Plan. It has also developed a Claiming Plan checklist and a checklist to use when submitting amendments to the Claiming Plan. Copies of these documents, along with a copy of the most recently approved version of the plan, are on file in the Mental Health Plan administrative offices. Claiming plans and any amendments will remain in effect from year to year. A Claiming Plan will not need to be amended, unless the scope of MAA is significantly changed or a new type of activity is undertaken. For example, a Claiming Plan must be amended when a new outreach campaign or program is instituted, or a new claiming unit performing MAA is created.

Claiming Procedures

Claims for MAA reimbursement are submitted quarterly to the State Department of Mental Health (DMH) by HHSA. A detailed quarterly invoice is prepared for each mental health unit participating in MAA, as identified in the claiming plan. County-operated programs are one unit; each participating contractor is a separate unit. A summary invoice is also prepared that aggregates all invoices submitted by mental health. An approved claiming plan covering the period of the claim must be in place before an invoice may be paid.

The County is required to provide DMH with complete invoice and expenditure information no later than December 31, following the fiscal year for which a claim is submitted. Invoice and expenditure information must be submitted to DMH prior to or with the County's cost report for the current fiscal year. DMH may approve the claim, return it for correction and/or revision, or deny the claim. The County may request reconsideration of a denied claim in writing within 30 days of receiving the denial.

The detailed quarterly invoice captures the time spent on MAA, the Medi-Cal percentage, expenditure and revenue information on a single spreadsheet.

MAA Training

All staff participating in MAA, and completing MAA activity logs, will attend MAA training sessions on at least an annual basis. Sign-in sheets will serve as a record of the individual's attendance. Training will be scheduled and provided at the direction of Mental Health Administration.

Reporting MAA Activities

MAA activities are reported to InSyst. The reporting requirements are somewhat different than what is required for direct services. For MAA, staff must report the following each time an MAA activity is performed:

- the day the activity occurred;
- the activity code (as a proxy for the name of the activity);
- the number of minutes spent on the activity;
- the name of the employee performing the activity.

A standardized MAA Activity Log has been developed; however, programs can develop their own as long as it contains the essential MAA reporting information. When programs develop their own form, they should forward it to the MAA Coordinator to ensure it covers the basic elements. The standardized forms are included as Attachments 1 and 2. Each activity log is to be signed by the employee before he/she gives it to the clerical staff responsible for entering data into InSyst Mental Health MIS. Activity logs may cover multiple days. Completed logs should be signed by the employee, and turned in to the person responsible for entering the information into InSyst on a timely basis, but no later than the fifth working day after the end of each month.

Document Retention

The County of San Diego has adopted a record retention policy that requires these records to be retained for seven (7) years. Program managers are responsible for storing signed, original versions of all MAA activity logs, outreach materials, and all documentation that supports the MAA claimed by their staff.

Becoming an InSyst User

Information on the amount and type of MAA activity performed by individual staff is entered into InSyst. Anyone who performs MAA activities needs an InSyst User ID so these activities may be entered into InSyst. Staff who provides direct services have InSyst identification numbers. Administrative and clerical staff who perform MAA activities will need an InSyst ID number as well. These ID numbers may be secured by calling UBH.

Quality Assurance; Monitoring

The quality of the MAA program will be monitored through quarterly reports from InSyst. The Mental Health Services MAA Coordinator will disseminate these reports to program managers, notifying them of any identifiable discrepancies found. These reports will provide managers with summaries of the amount of time reported to all MAA activities, by staff name. Program managers are expected to use the monitoring reports to:

- ensure that staff is reporting their MAA time accurately, using the correct activity codes;
- ensure that all staff that should be reporting MAA is doing so;
- ensure that MAA time is being reported consistently among staff in same classification.

Managers are required to ensure that corrective action is taken on any discrepancies they find or that have been identified by the MAA coordinator. Random reviews will take place to ensure that staff is reporting MAA correctly.

The MAA Audit File

An MAA audit file will be maintained at Mental Health Administration, and includes the following:

- a copy of the most recently approved MAA claiming plan for the County and for each participating contract agency;
- copies of current SPMP forms, and verification that each SPMP's license, where applicable, is current;
- job descriptions and/or duty statements for all staff participating in MAA;
- electronic or hard copies of the raw data used to calculate each quarterly percentage of MAA activity;
- electronic or hard copies of the reports used to establish the Medi-Cal percentage for each quarterly MAA claim;
- locations (with addresses) where MAA activity logs are kept on file, and where copies of information used in outreach or eligibility assistance activities are kept;
- copies of annual training schedules, training rosters, and materials used in training.

Who Can Claim MAA: An Overview

Clinical staff

- MAA may be used for client-based activities that are not part of a direct service or that are provided to an individual who does not have an open case anywhere within the system. MAA also includes outreach activities to inform individuals or groups about the availability of Medi-Cal and mental health services.

Administrators

- MAA includes program planning and contract administration.
- MAA includes outreach activities to inform individuals or groups about the availability of mental health services.

Clerical staff, Human Service Specialist and all other staff

- MAA includes activities that assist individuals, regardless of their case status, to apply for Medi-Cal or to access services covered by Medi-Cal.
- MAA activities include the administrative support clerical staff provide around outreach, contract administration, program planning, and crisis situations.

The MAA Activity Codes

A set of MAA activity codes has been developed for local mental health programs. The activities include:

Activity Code

401	Medi-Cal Outreach
457	Mental Health Outreach
404	Facilitating Medi-Cal Eligibility Determinations
481	Case Management of Non-Open Cases
451	Referral in Crisis Situations – Non-Open Cases
409	MAA Coordination and Claims Administration

MAA Activity Code Definitions

401 **Medi-Cal Outreach** – This code may be used by all staff in county and contract programs. Includes the following:

- informing Medi-Cal eligibles or potential Medi-Cal eligibles about Medi-Cal services, including Short-Doyle/Medi-Cal services;

- assisting at-risk Medi-Cal eligibles or potential Medi-Cal eligibles to understand the need for mental health services covered by Medi-Cal;
- actively encouraging reluctant and difficult Medi-Cal eligibles and potential Medi-Cal eligibles to accept needed health or mental health services;
- performing information and referral activity that involves referring Medi-Cal beneficiaries;
- referring Medi-Cal eligibles to Medi-Cal eligibility workers.

457 Mental Health Outreach – This code may be used by all staff in county and contract programs. Includes the following:

- informing at-risk populations about the need for and availability of Medi-Cal and non-Medi-Cal mental health services;
- providing telephone, walk-in or drop-in services for referring persons to Medi-Cal and non-Medi-Cal mental health programs.

404 Facilitating Medi-Cal Eligibility Determinations – This code may be used by all staff in county and contract programs. Includes the following:

- screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

481 Case Management of Non-Open Cases – May be used by all staff in county and contract agencies. Includes the following:

- gathering information about an individual's health and mental health needs.
- assisting individuals to access Medi-Cal covered physical health and mental health services by providing referrals, follow-up and arranging transportation to health care.

451 Referral in Crisis Situations - Non-Open Cases – May be used by all staff in county and contract programs. Includes the following:

- intervening in a crisis situation by referring to mental health services.

409 MAA Coordination and Claims Administration – This code may be used by all staff in county and contract programs. Includes the following:

- MAA Training

Appendix O Training/Technical Assistance

Appendix P **Adult AB 2726 Services** **for Adults 18 - 22**

Adult AB2726 Clients

Instruction Sheet for Quarterly Progress Mental Health IEP Report

This report is completed by the outpatient provider on a quarterly basis. It lists the progress towards the goals outlined on the Mental Health Treatment Plan (see *Appendix P*). This report is sent to the school contact (whomever is identified) and a copy is given or sent to the client. This report could be sent to the parent also if there is a release of information present and if the client agrees. The original report is maintained in the “Plans” section of the client’s chart.

QUARTERLY PROGRESS MENTAL HEALTH IEP REPORT

Program: _____

Address: _____

Telephone: _____

Patient Name:	DOB:
Therapist:	
Reporting Period: to	

Progress Rating: 1-Goal not met; symptoms stayed the same or got worse
2-Goal not met completely, but some progress made (1-50% of goal achieved)
3-Goal not met completely, but substantial progress made (51-99% of goal achieved)
4-Goal met or exceeded (100% of goal achieved)

GOAL # 1:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 2:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

GOAL # 3:

Progress: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Comments on goal/progress:

Scheduled Frequency of Sessions: **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐

Concerns with Attendance: No ☐ Yes ☐

Date of Contacts with School:

Therapist Signature

Date

Adult AB2726 Clients

Instruction Sheet for Mental Health Treatment Plan

When an outpatient (OP) clinic receives the AB2726 referral, the Special Education Services (SES) clinician making the referral has completed this Mental Health Treatment Plan. This plan guides the OP provider's client plan, as treatment goals need to be consistent. This Mental Health Treatment Plan is placed in the "Plans" section of the chart and is to be updated at each Benchmark/Short-Term Objective as outlined on the Plan. The Measurable Long-Term Goal has a six-month duration, because services on the Individualized Education Plan (IEP) are only valid for 6 months. After 6 months, a new Mental Health Treatment Plan with updated goals is to be written. At this point, there needs to be an IEP meeting to discuss continuation of services and to review and accept the updated goals. (Note: to reconvene an IEP meeting, the outpatient provider completes a Need for IEP Review-labeled as attachment #4- and forwards it to the school contact). The IEP review process could be completed by mail (rather than a formal meeting) if the client agrees, since they are 18 or over. The district could do an action form that states services will continue for 6 more months and the IEP team is in agreement with the goals. Once everyone signs the updated IEP, the provider needs a copy for the client's medical record. This six-month process continues until AB2726 services are discontinued.

*Please note that the form indicates when and how parents (or adult client) will be informed of progress on this treatment plan. These are the guidelines to follow in addition to the six month IEP process listed above.

**Be aware that the six-month updates to the standard OP provider client plan are also required for these clients.

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
SAN DIEGO MENTAL HEALTH SERVICES
MENTAL HEALTH TREATMENT PLAN

Date: _____ **Student:** _____ **Type of Service:** _____ **Start Date: ASAP** **Duration: 6 months**

Area of Need:

Present Level

Measurable Long-Term Goal:

Parents will be informed of progress <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Trimester <input type="checkbox"/> Semester <input type="checkbox"/> Other: _____ How ? <input type="checkbox"/> Annotated Goals/Objectives <input checked="" type="checkbox"/> Other: teacher, therapist	Periodic Review Dates 1. _____ 2. _____ 3. _____ 4. _____	Progress Toward Goal 1. _____ 2. _____ 3. _____ 4. _____	Sufficient Progress to Meet Goal <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____
--	--	---	---

Benchmark/Short-Term Objective: Within 2 months:
1. _____

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Benchmark/Short-Term Objective: Within 4 months:
1. _____

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Area of Need

Present Level:

Measurable Long-Term Goal:

Parents will be informed of progress <input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> Trimester <input type="checkbox"/> Semester <input type="checkbox"/> Other: _____ How ? <input type="checkbox"/> Annotated Goals/Objectives <input checked="" type="checkbox"/> Other: teacher, therapist	Periodic Review Dates 1. _____ 2. _____ 3. _____ 4. _____	Progress Toward Goal 1. _____ 2. _____ 3. _____ 4. _____	Sufficient Progress to Meet Goal <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____
--	--	---	---

Benchmark/Short-Term Objective: Within 2 months:

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Benchmark/Short-Term Objective: Within 4 months:

Date:
☐ Achieved
☐ Reviewed

Person(s) Responsible: client, therapist

Student Signature

Date

Signature of Parent

Date

Signature of Mental Health Service Representative

Date

Adult AB2726 Clients

Instruction Sheet for Need for IEP Review Form

The outpatient provider completes this form when an Individual Education Plan (IEP) meeting needs to be scheduled. Please note that there are multiple reasons for a meeting to be held. This form is forwarded to the school contact (whomever is identified) and a copy is maintained in the “Correspondence” section of the client’s medical record.

**COUNTY OF SAN DIEGO
DEPARTMENT OF HEALTH SERVICES
MENTAL HEALTH SERVICES**

NEED FOR IEP REVIEW

TO: _____ DATE: _____

FROM: _____ TELEPHONE _____

RE: _____ DOB: _____

A. We are unable to continue our delivery of mental health assessment services to your pupil _____, for the following reason:

_____1. Parent has not signed a mental health assessment plan.

_____2. Parent has failed to come in for scheduled assessment visits.

_____3. Parent has withdrawn permission for the mental health assessment.

_____4. Other/comments _____

B. This is to notify you of a substantial change to the IEP/Treatment Plan because:

_____1. Client has completed treatment.

_____2. Client is in need of change in mental health services level of care.

_____3. Child is not benefiting from his mental health services.

_____4. Parent no longer wishes to have treatment services identified on the IEP for the child through Short-Doyle/MHS.

_____5. Parent has had difficulty following through with the treatment plan.

_____6. Parent has moved to another district/SELPA

Other/comments _____

Appendix R MENTAL HEALTH SERVICES ACT - MHSA